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Will Your Computer Meet Your Case-Mix Informational Needs?

JANE FEDOROWICZ

Computers have historically played a secondary role in the running of a hospital. In the early days, the computer was viewed as a tool—an aid to the laboratory technician in the testing process, or a mechanized bookkeeping instrument for the billing and payroll department. Little by little, we saw the advent of computerization in other areas of the hospital. Admissions and nurses' schedules were added to the accounting systems, and EKGs were computerized.

Soon, hospitals found that they were purchasing many small computers. Accounting and patient information shared the mainframe computer, but laboratories and other clinical support functions required specialized equipment. Often, these systems were selected by the user departments, with the results being that no coordination or integration would be possible at a later date.

The mandate to base Medicare payments on prospective pricing (using DRGs) will now force hospitals to recognize the importance of integrating their information systems. Case-mix requirements stipulate the use of both medical and patient-care data. Given the scenario described, this task would be close to impossible. Hospitals are now asking: "Short of starting over, can we adapt our information systems to meet the needs of prospective payment?"

The outlook is not as bleak as it appears thus far. Let us begin to answer this question by ascertaining the requirements of a case-mix system.

Case-Mix Requirements

The Medicare prospective-payment system will place new demands on the hospital information system (HIS). Data from the general ledger, medical records, and billing must be combined to unite the diagnosis for a patient with services received and the cost of those services. For the first time, management will have to monitor physician actions and medical record procedures to ensure that the hospital is providing the correct mix of services to its patients and that it is doing so in a cost-efficient manner. What specific changes will this entail?

The major alteration resulting from the new government requirements mandates a change in management philosophy. A hospital has always been run as two separate organizations—the administrators control the finances and resources of the hospital, and the medical organization directs the volume of services provided to the patient. HISs have supported this dichotomy by providing financial and utilization data for management purposes and clinical information to support the medical functions. The change in philosophy results from the need for administrators to manage and control the utilization of resources and the cost of services for the overriding purpose of keeping the hospital solvent. Administrators will need integrated HISs to provide this utilization information.

In addition to the Medicare application, administrators are discovering that case-mix measurements have other uses in the hospital. These classification schemes are being applied to budgeting, planning, utilization review, and quality assurance. The basic requirements for each of these applications are the same: integration of financial and patient data. However, researchers have noted that each use of case-mix classification may require a different set of data, for example, different factors than those used for quality assurance are needed to classify patients for prospective payment schemes. In a study by the Hospital Research and Educational Trust, nine distinct classification schemes were identified [7]. Table 1 lists them, along with the major development objective of each.

The principle factor in most of these schemes is diagnosis (admitting and/or discharge); other important factors include the presence or absence of surgery, type of surgery, complications, comorbidity, severity of illness, age, and type of care. The designer of a case-mix system must be aware that

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Table 1. Purpose of Classification of Nine Case-Mix Schemes.

Utilization Review	Reimbursement	Quality Assurance	Management
Diagnosis Related Groups	MD-DADO	AS-SCORE	Generic Algorithms
ICD-9-CM List A	Patient Management Categories	Disease Staging	VA Multi-Level Care Groups
		Severity-of-Illness Index	

the same set of patient categories may not be appropriate for every application in the hospital. The system can and should be designed to accommodate different uses, especially now that administrators are finding that detailed utilization data are necessary for improving the financial performance of the hospital.

In a special report by the American Hospital Association on the management implications of the changes in Medicare policy, strategies for employing case-mix schemes for better financial management were developed [*2*]. These include methods for increasing productivity levels and better management of length of stay. Table 2 summarizes the strategies proposed by the AHA.

Paralleis to many of these strategies have been employed in the business world for years. Hospital administrators are now encountering the same problems that businesses have always faced: they must learn how to hold costs down in order to stay in business. The key to maintaining control over costs lies in the quality of information available to managers. In this respect, the Medicare proposal forces the manager to improve his access to information. How this is to be accomplished depends on the status of the HIS in place at this time. We turn now to a discussion of currently available HISs.

Trends in Hospital Information Systems

Initial attempts at computerization in hospitals led to the proliferation of the independently developed, stand-alone systems described earlier. Ball and Boyle classify these as Class A systems [*3*].

Hospital administrators are now encountering the same problems that businesses have always faced: they must learn how to hold costs down in order to stay in business. The key to maintaining control over costs lies in the quality of information available to managers.

As HISs became more advanced, some integration was introduced, usually based on financial applications. Integration categorizes a system as Class B in Ball and Boyle's terminology. A Class B Level 1 system primarily provides billing support. In these systems, admissions/discharge/transfer (ADT) and order entry interface with the billing system, providing a mechanism for charge capturing. Level 1 systems contain records of patient stay, but do not provide any continuity over time, since they are constructed to accommodate the billing function. Thus, medical records and test results must be maintained separately.

When a Class B system is capable of retaining historical medical record data, it is considered a Level 2 system. When an order is placed, the billing component is updated, and a historical record is the state of the art in HISs today.

Ball and Boyle also describe a Class C system, which is based on the medical record. The crux of this system is medical data rather than financial or administrative data, as in a Class B system. Few of these systems have been implemented, and they are still in the experimental stage.

An HIS can be obtained through three channels. These include time-sharing and shared-service vendors, purchased systems, and inhouse development. All three have been available for more than 20 years.

The price of hardware compels many hospitals to go outside for computer access. Time-sharing and shared-service vendors provide both hardware and software to hospitals. The hospital that cannot afford to purchase a machine or employ the extensive manpower needed to support the data processing function can pay these firms to use their programs and facilities. However, as the price of hardware plummets and HISs are developed for smaller computers, this alternative has become less attractive to even the smaller hospitals [*4,5*].

Most medium- to large-sized hospitals have found that the best source of applications software has been the commercial vendor. Hospitals can purchase software for most of their applications from firms specializing in the development of generalized application programs or can commission a vendor to develop a special application.

If a particular application is not available commercially, or if many changes to an off-the-shelf system must be made to render it useful to the hospital, the application may be developed inhouse. This is more time-consuming and more expensive than

Table 2. Case-Mix Financial Management Strategies.

Productivity Improvements	Length-of-Stay Management
Personnel Budgets	Discharge Planning
Inventory Management	Referrals to Other Providers
Utilization Evaluation of Capital, Equipment, and Services	Monitoring/Reductions in Inpatient Service Usage
Capital Investments Analysis	Internal Utilization Review and Quality Assurance Programs

purchasing a commercially available system and is only recommended for applications that cannot be obtained from a vendor.

In a recent study of Chicago-area hospitals, 30 percent of the hospitals had inhouse hardware only, 35 percent used an outside service vendor, and 35 percent used both inhouse and outside service vendors [6]. For current inhouse users, 35 percent of software programs were modified from a purchased package, 29 percent were developed by the inhouse staff, and 35 percent were developed entirely by outside contractors. [6].

The Chicago hospitals were also asked to estimate the percentage of total data processing services used by their financial, clinical, and administrative functions. The response demonstrates hospitals' orientation toward computerizing financial and administrative tasks: financial applications made up 73.8 percent of all data processing performed; clinical functions, 12.6 percent; administrative/statistics, 11.4 percent; and other, the remaining 2.2 percent.

Many of these financial applications are needed for a case-mix payment scheme; however, a true management tool requires the integration of clinical and patient information, found only in Level 2 or Class C systems. Unfortunately, most hospitals do not have these types of systems. Jacobs surveyed U.S. hospitals and found that, of those with more than 50 beds, 98 percent have computerized business and financial systems, in-hospital or shared. Approximately 700 of the 4,800 U.S. short-term hospitals have installed Level 1 HISs. Approximately 200 have installed Level 2 HISs [7].

Recent announcements of Level 2 systems' availability on small computers should alleviate this somewhat. These new systems should make HISs affordable to smaller hospitals, who had been left behind because of the high cost of large-scale integrated systems.

HIS Applications

The number and sophistication of HIS applications vary greatly across hospitals and vendors, whether or not they are considered Class A or Class B systems. Inevitably, however, hospitals tend to computerize laboratory and financial applications early on, following these with administrative and other support functions [8]. This observation is supported by the HFMA study, which included a survey of computerized applications in the 77 responding hospitals [9]. The responses indicate that most of these hospitals do not have a fully integrated HIS that could provide the comprehensive set of information needed for a case-mix system capable of monitoring costs and services to the hospital. According to Kukla and Bachofer, the HIS will need ". . . to provide information on the types of patients admitted to the hospital and the types of services offered to patients during their hospital stay. They also will be equipped to handle more sophisticated analysis of those factors that determine the total cost of hospital services, including the volume of services produced, productivity of resources used, and price of resources. In addition, hospitals will develop greater sophistication in forecasting cost and utilization" [10].

These capabilities imply that the HIS will be an integrated system providing on-line entry and retrieval of all patient-related service data in the hospital. The requirements of case-mix also imply that the HIS maintain a high level of reliability in the content and completeness of its data base. Where do hospitals stand relative to the requirements of such a system?

The bottom line is that very few hospitals will be able to easily adapt their present HIS to a full-fledged case-mix payment and planning system.

Most medium- to large-sized hospitals have found that the best source of applications software has been the commercial vendor.

To answer this, let us examine some of the results of the Chicago HFMA survey. Respondents were asked to indicate whether each application area (in a list of 95) was performed manually or on the computer, or if plans for automation were approved for implementation in the near future. A subset of 26 applications that are considered representative of the applications needed for case-mix construction are contained in Table 3.

The survey shows that most (but not all) of the hospitals have computerized their admissions and billing functions, which are two of the sources of data required in a case-mix application.

Smaller numbers of hospitals have financial and administrative support for management tasks of budgeting and planning. The laboratory and pharmacy are somewhat automated, although they probably use a stand-alone minicomputer in many hospitals. The remaining necessary applications are computerized in only a small percentage of the responding hospitals.

Medical records and ancillary services remain manual systems in the majority of these hospitals. Two-thirds of the hospitals do not plan on implementing interdepartmental communications in their medical areas in the foreseeable future. Applications such as nurse staffing, which should be part of the planning function, are also not computerized. The bottom line is that very few hospitals will be able to *easily* adapt their present HIS to a full-fledged case-mix payment and planning system.

Case-Mix Implementation

An estimated two years of development time may be required to set up a cost-accounting system for case-mix analysis [11]. Many data processing departments anticipated the new Medicare requirements and began development ahead of time.

One of the first uses of the cost-accounting data produced by a case-mix system should be to verify the case-mix index (CMI) assigned to the hospital by HCFA. A retrospective study of 1980 Medicare billings, on which CMIs are based, could lead to a higher index (and, therefore, higher revenue). Additional benefits may also

Table 3. 1981 HFMA Survey Results

Application Area	Totally Manual	Automated	System Status within 1 Year	1-3 Years	Total Responses
Administrative					
Key Factor Performance Statistics	24	24	6	12	66
Forcasting/Simulation	27	15	7	14	63
Admissions					
Patient Information Collection	4	54	8	9	75
Patient Transfers and Discharge	5	58	8	6	77
Business Office					
Inpatient Billing	1	66	5	4	76
Medicare/Medicaid Reporting	18	44	6	4	72
Financial Analysis of Department Performances	7	54	7	6	74
Annual Budget Preparation	16	43	8	8	75
Exception Reporting of Performance Analysis	25	33	6	7	71
Rate Setting	37	16	6	10	69
Clinical Laboratory/Pathology					
Daily Log of Tests Requested	28	22	11	11	72
Online Data Acquisition	22	23	11	10	66
Charge Capturing	20	35	9	10	74
Radiological Services					
Results Reporting	44	7	7	14	72
Medical Areas-Common Functions					
Order Entry	34	18	6	16	74
Results Reporting	40	9	5	19	73
Progress-Reports (observations, diagnoses)	48	5	1	17	71
Interdepartmental Communications	47	10	4	11	72
Medical Records					
Patient-Number Retrieval	25	23	13	10	70
Disease Index	28	24	5	14	71
Patient-Record Storage and Retrieval	49	9	5	11	74
Utilization Review	40	12	5	14	71
Nursing Services					
Results Reporting and Chart Preparation	47	9	3	16	75
Staffing and Patient-Load Records	50	5	6	13	74
Pharmacy					
Filling Medication Orders	35	18	11	12	76
Patient Drug Profiles	26	23	13	11	73

be incurred by this activity. Rodney Klein of the Jewish Hospital of St. Louis discusses these benefits: "You develop a profile by physician and product line, at least on the revenue side. You can pinpoint trends and get valuable management and marketing information by going back to 1980" [*12*].

The retrospective studies can be coupled with demographic information to provide the manager with forecasts of the changing service requirements of a shifting population. As can be imagined, this type of system will require data from many computer files. Let us examine some alternative sources of data and processing.

Shared-service vendors comprise one source of case-mix applications. Typically, service is limited to Medicare billing and DRG computation. Advanced applications for cost accounting and planning purposes are not yet available through this outlet. However, these shared-services can be used to fill the gap until a tailored system is introduced into the hospital.

Some commercial vendors have incorporated DRG analysis into their HISs. Hospitals currently using their systems can add on a module for the new billing system. Again, these systems provide the minimum analysis, and sophisticated decision support is not yet available.

Inhouse development or contracting with consultants are the only currently feasible alternatives to providing the decision-support capabilities that administrators want and

need. There are ways of providing this support. One is to use the hospital-wide data base and computer system, and the other is to "down-load" needed data to a microcomputer for the administrator's use. Both have their advantages.

The degree of difficulty in accessing an HIS for the new application depends upon the way in which the data are stored. Many HISs are "file-based"; each application has its own file containing all of the data needed to run its programs. If more than one application uses overlapping pieces of data (for example, patient name and number), these are replicated in each file. When a new application is to be developed with new data requirements, new files are created. In order for an administrator to access the data stored in this way, the application will be limited to accessing data currently stored, or new files will have to be constructed. Both require a great deal of development time. Some hospitals circumvent the problems of a file-based system by manually computing and/or entering DRGs to the Medicare billing system. This shortcut method should be only an interim step until a better system can be implemented.

Many hospitals have replaced their file-based systems with data-base technology. A data-base management system (DBMS) is a collection of interrelated data that can be used by many applications through a common base of software. DBMS software adds great flexibility to an HIS, enabling changes to be made to the data base or to the programs' accessing it with less effort and less expense than in file-oriented systems. DBMS technology is used in some, but not all, Level 2 and Class C systems. A DBMS provides the level of integration needed for obtaining accurate cost information [*13*]. In addition, most have a user-oriented query facility that allows the nonprogramming user to access and manipulate the data base. It is this query language that would enable the administrator to directly ask planning-related questions of the system without having to wait for a program to be written. One caution should be noted here: query languages require a great deal of system time and overhead, taking away computational power from other applications using the data base.

One of the first uses of the cost-accounting data produced by a case-mix system should be to verify the case-mix index (CMI) assigned to the hospital by HCFA.

Care should be taken that normal hospital processing does not suffer due to its overuse.

This caution is one of the main reasons for providing the administrator with a microcomputer (and it applies to a file-based system, as well). Historical usage data can be copied to a microcomputer, freeing up valuable mainframe time. The micro user has the full use of the system and its data, and can manipulate it in any way without affecting other hospital users. New, easy-to-use software, including decision-support systems, spread-sheet analysis, and word-processing programs, render the micro accessible for most uses. These systems are cheaper than their mainframe counterparts; their major limitations are the smaller amount of data that can be accessed and their slower manipulation speed.

All of these technologies can be used to derive different case-mix constructs for the diverse objectives of a particular hospital. Obviously, a DBMS or microcomputer will simplify the process, but file-based systems are also feasible. The key problem is whether or not all of the requisite data are being collected, and, if so, whether they are accessible in the form needed by the case-mix programs. An equally important issue concerns the reliability of the data. The old adage, "garbage in, garbage out," is especially important when all the data upon which decisions are based are stored in the computer.

New, easy-to-use software, including decision-support systems, spread-sheet analysis, and word-processing programs, render the micro accessible for most uses.

Conclusion

Hospitals lag behind their corporate counterparts in the sophistication of their computer systems. Much information in hospitals is still processed manually, and that which is computerized is not always accessible in the format or combination needed. When faced with case-mix requirements, hospitals are finding that automation and integration of information are imperative. Improved cost-accounting systems must be developed in order for a hospital to survive in an increasingly competitive industry.

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Nurses, Political Participation, and Attitudes Toward Reforms in the Health Care System

ELISABETH MOORE and DEBORAH OAKLEY

Leading nursing organizations have adopted policy statements supporting change in health care service patterns, including greater recognition and autonomy for nurses. The changes for nurses will be influenced by trends in health care generally, and by changes (or the lack thereof) in the structure of health care institutions, in funding, and in rules and regulations dealing with all aspects of health care. It is, therefore, important to understand more about nurses' attitudes toward changes in our system of care.

Attitudes of nurses and other health care providers, including physicians, optometrists, and physical therapists, have been studied, but in purely descriptive ways, with little attention to analysis of the correlates of attitudes [*1-7*]. Nor has sufficient attention been paid to the relationship between political participation—a means of effecting change—and nurses' attitudes. Previous studies have shown that nurses tend to register, vote, and participate in higher proportions than does the general population, but these activities have not been linked to attitudes about health care reform [*8-10*].

The current study was intended to measure the degree of political participation, the types of overall health system change sought by a local group of nurses, and the characteristics associated with varying degrees of support for change. The model specified background, personal, and political variables as affecting attitudes toward change in the system. The tool used was adapted from a questionnaire developed and used by the Office of Public Affairs of the National League for Nursing, supplemented by items adapted from a series of studies on elections and political participation [*11-15*]. Content validity of the original instrument was enhanced by the participation of the NLN staff, who are experts in public affairs, and by review of the instrument by policy participants on the faculty of the University of Michigan. As outlined by Moore, a test-retest procedure was used to estimate the reliability of the questionnaire [*16*]. A convenience sample of 18 registered nurses, representing a variety of backgrounds and work settings, completed the questionnaire. Approximately one week later, the same individuals completed the questionnaire a second time. Eighty-eight variables were matched and tested for reliability using the chi-square test, since the responses were categorical. For 73 percent of the variables, there was agreement on the test-retest. Two-thirds of the remaining variables had multiple categories, with responses generally in the same direction or categories in both tests. Items with low reliability were eliminated from analysis.

Eleven items on political participation provided a measure of the number of political activities in which each respondent participated. The internal consistency of this scale was tested by Cronbach's alpha, which was a satisfactory 0.78 [*17*]. Another scale was developed by averaging the ratings given to four items that dealt with the appropriateness of nurses' roles in politics. Cronbach's alpha for this scale was a moderate, but acceptable, 0.69.

Finally, 12 items that measured whether the respondent favored change in the health care system did not achieve an entirely satisfactory reliability coefficient, with a Cronbach's alpha of only 0.59. Factor analysis, using a principle components solution with one iteration and varimax rotation, showed that these items grouped themselves into five different factors. In other words, the reliability coefficient was low because the items measured several dimensions.

Method

In July, 1980, a six-page, 41-item, closed-ended questionnaire was mailed to a one-in-nine sample of registered nurses licensed by the State of Michigan in 1979 and residing in the (then) Second Congressional District of

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*Table 1. Percentages Agreeing and Disagreeing with Items on Nurses' Roles in Politics**

Item	Percentage				
	Strongly Disagree (1)	Somewhat Agree (2)	Somewhat Disagree (3)	Strongly Agree (4)	$\bar{X}$
I feel it is all right as part of the professional role for nurses to participate in politics.	2.2	16.1	2.9	78.8	3.71
It is natural as part of the professional role for nurses to seek political careers.	4.4	32.4	27.2	36.0	3.0
Political participation is very important for nurses.	2.9	34.8	8.7	53.6	3.39
Nursing organizations should help nurses be effective political participants.	6.5	30.2	12.2	51.1	3.26
				Index Average	3.34

*The first two items are reversed from the wording presented on the questionnaire in order to construct an overall average score.

Michigan. One follow-up postcard was sent as a reminder. Five hundred questionnaires were mailed; 389 were deliverable (the list was one year old). Of these, 153 were returned, for a response rate of 38.6 percent (a rate comparable to other mail surveys, including those with nurses as respondents) [*18*].

Characteristics of the respondents

Slightly more than 97 percent of the respondents were female. The average age was 41.4 years; 38 percent were under 35 years of age, and 25 percent were over 50. Eighty percent were currently employed in nursing, with 64 percent customarily working a 40-hour week, 32 percent working less, and 4 percent working more than 40 hours weekly. A relatively large proportion, 33.3 percent, held a baccalaureate in nursing. Forty percent had graduated from diploma programs, 12 percent held an associate degree in nursing, another 12 percent had master's degrees, and 2 percent had obtained doctorates.

Sixty-five percent of the nurses in the study worked within a hospital or nursing home setting, and almost 13 percent were employed in a community or occupational health setting. Fifteen percent were faculty members, clinical nurse specialists, or upper-level hospital administrators, and 7.5 percent worked in doctors' offices or were nurse practitioners.

When compared to national statistics on the characteristics of nurses, the sample reported here was similar to the national figures in its distribution by sex and in labor force participation rates, but was more highly educated and held positions that are associated with greater educational preparation [*19*].

Results

Respondents generally approved of nurses' participation in politics. As shown in Table 1, for the four items constituting a variable called "political role of the nurse," almost everyone agreed, either strongly or somewhat, that participating in politics is compatible with nurses' professional role. More than 80 percent strongly or somewhat agreed that political participation is very important for nurses and that nursing organizations should help nurses to be effective in politics. The least support was provided for the idea that it is natural for nurses to seek political careers, but two-thirds favored even this item. On a scale of one to four, with four assigned to "strongly agree," the average score for the entire index was 3.34, clearly on the end of the scale favoring political participation as an approved part of the role of nursing.

Nurses in this study reported a high level of participation in the political process, as shown by scores on the participation variable constructed from the items shown in Table 2. Almost all were registered to vote at the time of the survey and said that they usually voted in elections for President. Two-thirds or more said that they usually voted in primaries and in elections for their city council, mayor, and school board. A similar proportion had made at least one persuasive contact with an elected official. The least popular activities were "influencing others to contribute time or money to a candidate" and "joining a political party," but more than one-quarter had done one or both of these activities. Six percent said that they had participated in all of the activities listed, and everyone reported participating in at least one; more than 80 percent had participated in five or more, and more than two-fifths reported that they had participated in eight or more activities.

Table 2. Percentage Participating in Political Activities

Activity	Percentage Participating
Usually vote in elections for president	96.4
Registered to vote	94.3
Usually vote in city council or mayoral elections	81.0
Usually vote in primaries	68.2
Ever written a letter or telephoned an elected official to try to influence their vote on any issue	65.3
Usually vote in school board elections	63.2
Even worn a campaign button or placed a campaign sticker on the car bumper	56.8
Ever contributed to a political party or an election campaign	48.6
Ever worked on behalf of a candidate for political office	33.8
Ever joined a political party	31.8
Ever influenced others to contribute time or money for any candidate for elective office	29.9
Average Score = 6.3 activities	

Table 3. Percentages Agreeing and Disagreeing with Items on Perceptions of Nurses' Current Political Activities

Item	Percentage				
	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	$\bar{X}$
I feel that family responsibilities have kept nurses from participating in politics.	17.0	42.2	25.9	14.9	2.4
Nurses' knowledge about politics is limited.	11.7	35.8	24.8	27.7	2.7

Respondents were fairly evenly divided in their perception of reasons for nurses' participation or lack of participation in politics. As shown in Table 3, 59 percent agreed either strongly or somewhat that family responsibilities have kept nurses from participating in politics, but only 48 percent agreed that nurses' knowledge about politics is limited. Unfortunately, the first item in this index contains two separate parts. Respondents may have felt that nurses do participate in politics. It is impossible to tell whether disagreement conveyed this perception or a disagreement with the explanation given for nonparticipation; the item was eliminated from further analysis.

The last two political variables were "party" and "political thinking." Twenty-three percent considered themselves to be Democrats, 34 percent to be Republican, 37 percent to be Independents, and 6 percent to belong to another party. To measure political thinking, respondents reported whether they were conservative, moderate, or liberal. Twenty-two percent considered themselves to be conservative, 62 percent to be moderate, and 16 percent to be liberal.

The degree of support for change in the health care system was measured using four items about general issues and eight that dealt more specifically with health insurance. As shown in Table 4, the highest degree of consensus, 92 percent, was found to favor reform to control costs and provide adequate care. Two-thirds or more of the respondents favored prevention as a major focus of any national health plan and eligibility for insurance coverage regardless of either medical history or ability to pay. In addition, more than half favored a comprehensive plan for any national health insurance, preferred a comprehensive to a catastrophic plan, and felt that monetary incentives should be used to improve the availability of health care services in rural and inner-city urban areas. Fewer than one-fifth of the sample favored total public (as compared to mixed public and private or totally private) financing of health care. Even fewer were in favor of federal cost controls as a mechanism to contain costs or were against phasing in a national health insurance plan (should one ever be introduced).

Two-thirds of the respondents favored only a moderate amount of change in the health care system; a meager 7 percent favored nine or more of the change items, and 30 percent favored fewer than a third of the items. It appears that the nurses surveyed would have supported cost reforms, substantive changes favoring prevention, and insurance protection for more people, but they would not favor more federal intervention.

To determine the relationships between attitudes and political participation, correlations and analysis of variance were run. Most of the statistically significant coefficients obtained were not strong, as is often the case in social science research. All relationships cited did not meet the criterion of statistical significance at or below 0.05.

In the sample studied, there were no significant differences in political activity according to age, education, professional organization membership, party, or political thinking. In other words, people who differed on these characteristics had similar levels of political activity, an average of six out of a possible 11 activities for most subgroups. Of all the variables measured, the strongest relationship with participation was for the variable measuring agreement with the idea that nurses' knowledge of politics is limited. Although this variable was not related significantly in the sample as a whole, analysis by strata indicated a significant relationship among those aged 36 to 50 years (rho=0.367, N=52) and those who considered themselves liberals (rho=0.54, N=22). In both these groups, those agreeing more strongly that nurses' knowledge about politics is limited were more active.

Education was significantly related to attitude (eta=0.278, N=150). Those with more academic preparation in nursing had attitude scores more favorable to change in the health care system. The mean number of

Table 4. Percentage Favoring Change in the Health Care System

Item	Percent Favoring
Thinks reform is necessary to control costs and provide adequate care	92.4
Thinks preventive services should be a major focus of a health plan	88.8
Feels eligibility for comprehensive insurance should be allowed regardless of medical history	84.3
Feels eligibility for comprehensive insurance should be allowed regardless of ability to pay	68.2
Favors comprehensive national health insurance plan	59.3
Favors a comprehensive over a catastrophic health insurance plan	58.3
Thinks monetary incentives should be used to improve availability of health care services in rural and inner-city urban areas	58.2
Favors including more benefits in any national health insurance plan	36.0
Thinks the federal government should have the primary responsibility for administering a national health insurance plan	16.2
Favors cost containment through federally controlled mechanisms	14.5
Thinks a new health insurance program should be introduced as a total package, not phased in	14.4
Favors total public financing of health insurance	10.6

changes favored, on a 12-point scale, was 4.2 for AD-prepared nurses, 5.4 for diploma graduates, 6.0 for BSNs, and 6.3 for those with graduate degrees.

Three political variables were also related significantly to attitude. Political thinking (eta=0.218, N=129) and political party identification (eta=0.218, N=129) were related among the sample as a whole. Those who thought of themselves liberals favored an average of 6.5 changes, while moderates favored 5.6, and conservatives, 4.7. Democrats favored the most change, with an average score of 6.3, as compared to Independent's 5.6 and Republican's 5.1.

Because the items measuring change were not unidimensional, the five factors produced by factor analysis were also examined in analyzing relationships with other variables. These five factors dealt with the comprehensiveness of any national health insurance plan, the proper federal role in health care, eligibility criteria for health services, the phasing in of any health insurance program, and the range of benefits that government services should provide. Altogether, the five factors explained 60 percent of the variance in the items as a group.

The more highly educated the respondents, the higher the proportion favoring comprehensive government health services (eta=0.27, N=149) and the higher the number of government-provided health services favored, except that BSNs favored more services than those with graduate degrees (eta=0.29, N=150). Moderates and conservatives were much less likely to favor a strong federal role in the health care system when compared with people who identified themselves as liberals (eta=0.23, N=138).

In addition, the higher the number of political activities reported, the larger the proportion favoring eligibility for government health care regardless of ability to pay, medical history, and other restrictions (rho=0.173, N=129).

Discussion

In general, the nurses sampled had the expected high level of political activity and favored only moderate change in the health care system. Few supported increasing federal intervention. Seventy-four percent of the Second District nurses favored a combination of private and public financing, and a high proportion favored no change or, at most, incremental change. This proportion was higher than the figures for any sex, age, racial, educational, health status, income, religious, or insurance coverage groups in a representative sample study of the general population in Rochester, New York [*20*]. However, the Second District nurses were less likely than the Rochester respondents to favor either extreme of mostly individual or mostly governmental coverage.

As expected from work on other topics, the basic background categories produced by educational preparation were significantly related to some of the attitude factors, although these variables have generally been related (along with age and educational preparation) to attitudes about change within nursing [*21-23*].

The relationship between political participation and one aspect of the change scale suggests that, overall, in the group studied, political activity was related to favoring change in eligibility associated with attitudes about other elements of change in the health care system. It is likely that nurses in the congressional district were drawn into political activities for reasons other than wanting to effect change in the health care system.

Conclusion

Since the educational distribution of the group studied differed from that of nurses in general, these results cannot be generalized to the profession. However, the findings reported here do suggest that it may be useful to study political participation and attitudes about particular legislative issues as nurses become more involved in politics.

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A Clinical Ladder

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Quality patient care can be achieved only if the working environment in which a nurse practices is one that encourages staff development and recognition of self-worth. "Historical patterns of compensating nurses for professional service mitigate against nurses with the highest quality skills rendering acute care to the patients" [*1*]. The path for advancement in nursing has generally been through promotion in administrative positions. The best nurse became the head nurse, who was often then promoted to supervisor. Dr. Lysaught states that the "hospital promotion ladder has taken them (nurses) further away from the goal that brought people into the profession in the first place" [*2*]. Hence, the missing link in the reward system needs to be developed and operationalized through a system for clinical advancement in nursing practice. This article shall discuss a model for the development of our clinical ladder at the Greater Baltimore Medical Center in Maryland.

The purposes for a clinical ladder are to provide nurses with the opportunity for advancement while remaining in the clinical field. The program will provide three major benefits. First, the promotional track will encourage those in the hospital to remain, thus reducing nursing orientation time and cost. The second benefit will be the care given to the patient. The quality of care will improve as the skills and competencies of the "bedside" nurse increase. Third, it will encourage nurses that are not working to return to the hospital setting. The literature states that clinical ladders provide increased job satisfaction, improved retention, improved rewards for competence in clinical skills, and maintenance of a high quality of patient care [*3–5*]. Maslow has described the hierarchy of needs as an interdependent phenomenon, not a stepladder. Hence, while meeting the employee's physiological, safety, and social needs, we must also direct our attention to the quest to satisfy self-fulfillment needs [*6*].

Herzberg has studied the factors that constitute job satisfaction and dissatisfaction. His work has found that supervision and working conditions are usual determinants of dissatisfaction, while the nature of the work, accomplishments, and responsibilities are associated with job satisfaction. It follows, then, that reasons for staying and job performance are more positively influenced when more "motivators" are provided in the job. Reasons for leaving are identified as factors relating to job security and interpersonal relationships [*7*].

The goal of the clinical ladder is to provide discrete advancement positions and simultaneously promote job satisfaction. Studies have shown that, with increased job satisfaction and recognition of performance, there is an improved rate of retention and motivation to excell [*8,9*]. For example, M. D. Anderson Hospital and Tumor Institute experienced a 25 percent decrease in overall turnover [*10*]. Thomas Jefferson University Hospital in Philadelphia consistently showed a decrease in its turnover from 50 percent to 25 percent over five years [*11*]. Rush-Presbyterian-St. Luke's Medical Center claims a decrease of 14 percent in turnover in staff nurse positions since the career advancement system was implemented [*12*].

With increased retention, the costs for recruitment and orientation decrease. Adjusted for inflation, estimates of the cost for replacing an RN range up to $2,000 [*13*]. At Greater Baltimore Medical Center, it has been roughly calculated that it costs between $2,865 and $4,785 to hire and orient a new nurse. This figure includes recruitment advertising, the nurse recruiter's salary, processing time, pre-employment physical, and orientation costs (see Tables 1, 2, and 3).

The most serious costs of turnover, however, are not these administrative and procedural costs but the cost incurred on the wards or in the department where the turnover has occurred. There may be a perceptible slowing down in work effort of the employee as the date of her (or his) termination approaches. There is usually no replacement available for a time, and the remaining department members must continue under a greater and more frustrating workload.

Developmental Timetable

The development of the career ladder involves several stages, with many decisions of process and policy needed. To proceed in an orderly manner, the following timetable is proposed:

I. *Formation of a Professional Clinical Committee*

The success of a clinical ladder depends a great deal on the committee that develops it. The committee should have equal numbers of supervisors and nonsupervisors and of critical care and noncritical care nurses. The size of the committee should be large enough to provide a wide range of input. The committee members can be volunteers or those selected by management. Our committee consists of eight members.

Once the committee is appointed, there must be a commitment by administration to free the members from their routine duties so that they may develop the clinical ladder. Throughout the developmental process, there

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Table 1. General recruitment and personnel orientation costs for registered nurses

Total RN's hired FY '82—104

Recruitment

A.	Advertising		$10,000
	Newspaper Ads	(7,800)	
	Bank, Publications, etc.	(2,200)	
B.	Recruitment Visits (Recruiter Time × $10)		240
C.	Nurse Recruiter Time with Nurse Average Time with nurse 1 1/2 hr. × $10)		1,560
D.	Processing Costs		26,520
	1/2 hr. per nurse × $4	(208)	
	Badges $3 each	(312)	
	Physical exams $250/each	(26,000)	
		*TOTAL	$38,320.00

*Average recruitment cost = $368.00 per RN

Personnel Orientation

A.	Personnel Orientation (1 hr. × $4 × 12 sessions ÷ 104)		$ .46
B.	Inservice (2 hr. × $15 × 12 sessions ÷ 104)		3.46
		*TOTAL	$ 3.92

*Average personnel orientation cost per RN

Table 3. Cost to recruit and orient a nursing graduate

Approximately 18 nursing graduates hired in FY '82

A.	General Orientation		$ 284.69
	GN $7.75 × 32 hrs.	(248.00)	
	Instructor $10.32 × 32 hrs. × 2 (sessions) ÷ 18	(36.69)	
B.	Clinical Orientation (10 weeks)		
	Weeks 1 through 4		2,080.00
	GN $7.75 × 160 hrs.	(1,240.00)	
	Perceptor $9.00 × 160 hrs.	(1,440.00)	
	Weeks 5 through 6 (each person counted as 1)		
	GN 7.75 × 80 hrs. = 620.00 ÷ 2	(310.00)	
	Perceptor 9.00 × 80 = 720.00 ÷ 2	(360.00)	
	Weeks 7 through 8 (each person counted as 1)		0
	Week 9 through 10 (each person counted 1/2 on off shift)		749.20
	GN 7.75 + .99	(349.60)	
	Preceptor 9.00 + .99 × 80 = 799.20 ÷ 2	(399.60)	
C.	Average Recruitment Cost per RN		368.00
D.	Average Personnel orientation per RN		34.00
		*TOTAL	$4,785.89

*Per nurse

should be open communication with as many members of the profession as possible in order to obtain feedback from all sectors.

II. *Clinical Factors of the Clinical Ladder*

The first mission of the committee is to develop a list of the many different functions that make up the nurse's job. Truly, the clinical ladder must be made "by the nurse, for the nurse." From the list, the committee then needs to define the major factors or categories, such as clinical practice, education, and research. It is important that these factors be measurable, objective, and applicable to all nurses. Additionally, the factors must be readily understood in clear terms.

Once the factors are defined, criteria must be developed against which performance will be measured, and several important issues should be kept in mind. For example, can all RNs fit into a performance level with the criteria written? For each performance level, the nurse must either meet or not meet the criteria. Therefore, the criteria must allow for quantifiable and qualifiable standards. With the criteria in place, the minimum acceptable performance for each level must be defined. It is assumed that satisfactory performance at each level presumes continued performance of duties at all lower levels.

The committee, at this point, may wish to determine a weighting scale. A weighting scale determines the relative value of each factor within the plan as a whole. This provides a definite, individualized clinical ladder, because the weight values usually reflect the department's philosophy.

Table 2. Cost to recruit and orient an experienced nurse

Approximately 86 experienced nurses hired in FY '82

A.	General orientation		$ 334.00
	GSN $9.00 × 32 hr.	(288.00)	
	Instructor $10.30 × 32 hr. × 12 sessions ÷ 86	(46.00)	
B.	Clinical orientation (3 weeks average)		2,160.00
	GSN $9.00 × 120 hours	(1,080.00)	
	GSN (Buddy) ($9.00 × 120 hours)	(1,080.00)	
C.	Average Recruitment Cost per RN		368.00
D.	Average Personnel Orientation Cost per RN		3.92
		*TOTAL	$2,865.92

*Per Nurse

III. *Clinical Positions for Each Level*

The clinical positions at each level should be a finite number. The specific numbers should reflect the clinical needs and money available. The process of incorporating the number of positions can be staggered over four or five years so as to decrease the overall financial impact, as seen in Table 4. A suggested four-year implementation plan allows for the following:

Year One

1. Two (2) clinical specialists—new positions

Table 4 Proposed implementation of clinical ladder positions

FY '83			
January	'83	Clinical Specialist	$ 12,500
April	'83	Clinical Specialist	6,250
		Six Clinician III	30,000
		Subtotal	$ 48,750
		Total 2 Clinical Specialists 6 Clinician III	
		Reduction of 3 GSN positions April '83	-- $ 13,500
		TOTAL	$ 35,250
FY '84			
July	'83	Clinical Specialist	$25,000
October	'83	Two Clinician III	30,000
		Eight Clinician II	6,000
January	'84	Clinical Specialist	12,500
		Two Clinician III	20,000
		Eight Clinician II	4,000
April	'84	Two Clinician III	10,000
		Eight Clinician II	2,000
		Subtotal	$109,500
		Total 2 Clinical Specialists 6 Clinician III 24 Clinician II	
		Reduction of 3 GSN positions One each in October, January, and April	-- $ 27,000
		TOTAL	$ 82,500
FY '85			
July	'84	Two Clinical Specialists	$ 50,000
		Two Clinician III	40,000
October	'84	Two Clinician III	30,000
January	'85	Two Clinician III	20,000
April	'85	Two Clinician III	10,000
		Subtotal	$150,00
		Total 2 Clinical Specialists 8 Clinician III	
		Reduction of 4 GSN positions One each in January, October, January and April	-- $ 45,000
		TOTAL	$105,000
FY '86			
July	'85	Three Clinician III	$ 60,000
		Six Clinician II	6,000
October	'85	Six Clinician II	4,500
January	'86	Three Clinician III	30,000
		Six Clinician II	3,000
April	'86	Six Clinician II	1,500
		Subtotal	$105,000
		Total 6 Clinician III 24 Clinician II	
		Reduction of 3 GSN positions 1.5 in July and January	-- $ 40,500
		TOTAL	$ 64,500

2. Six (6) clinician III—3 new positions, 3 GSN upgrading

Year Two

1. Two (2) clinical specialists—new positions
2. Six (6) clinician III—3 new positions, 3 GSN upgrading
3. Twenty-four (24) clinician II—upgrading 24 GSN positions

Year Three

1. Two (2) clinical specialists—new positions
2. Eight (8) clinician III—4 new positions, 4 GSN upgrading

Year Four

1. Six (6) Clinician III—3 new positions, 3 GSN upgradings
2. Twenty-four (24) clinician II—upgrading 24 GSN positions

The early implementation of clinical specialist positions is particularly important. These new clinical positions are needed to provide sufficient clinical expertise and develop-

Table 5. Clinical Promotion Assessment Committee.

Committee Responsibilities

I. Establish standard procedure for processing candidates
   A. Review evidence of candidate's performance as submitted by candidate to committee
      1. Care plans and patient assessments
      2. Evidence of discharge planning
      3. Education program participation—attendance, presenter, evidence of self-initiative
      4. Committee membership and participation on same
      5. Recommendations for promotion from supervisor and a coworker in an advanced position who has observed performance.
      6. Committee may require retrospective chart review to provide evidence of ongoing performance
      7. Committee may observe performance of candidate
   B. Committee interviews candidate and explores questions to assist in assessing qualifications for promotion

Promotional Process

I. Committee reaches a recommendation within 30 days of receipt of evidence material and forwards recommended decision to coordinator
   A. Provides written summary of decision to candidate and coordinator, identifying strengths and weaknesses
   B. Meets with candidate, if so desires, to review recommendations
II. Final approval for advancement rests with the coordinator. In most cases, the coordinator will accept the recommendation of the committee. Should the coordinator disagree with the committee recommendation, the Assistant Director or Director of Nursing will review the material

Committee Membership

Two staff nurses, two members of nursing management, one staff development instructor, one nurse practitioner, one clinical specialist.
In addition, the committee may call upon clinical experts from specialty areas as needed.

ment of the clinical nursing staff. Therefore, the ladder, in essence, will be implemented from two directions at once.

IV. *Implementation*

Once the levels and available positions are defined, the plan must gain administration approval. Having accomplished the required approvals, the actual implementation with the nursing staff should occur smoothly if the committee has maintained open communication throughout. Series of meetings with the nursing staff, supervisors, and management should be held in order to assure a complete understanding of the clinical ladder, its requirements, and its policies. The initial promotions in the first year should occur according to the procedures to be followed in subsequent months. A Clinical Promotion Assessment Committee is suggested to allow an objective evaluation for the finite numbers of available positions.

Table 6. Clinical ladder levels.

Position Description: General Staff Nurse (Clinical Step I)

General Description:

The general staff nurse is accountable to the standard of practice described in the Clinician II job description but will be expected to perform as a beginning practitioner only. She participates as a member of the patient care team and cares for selected patients. Through the formalized orientation program, she becomes knowledgeable about department procedures, policies, and standards of care related to the patient. The general staff nurse functions under, and is responsible to, the supervisor.

Education:

Graduate of an accredited school of nursing

Experience:

No experience on returning after being inactive. Experienced nurse will fit into this level during the orientation/probationary period.

Minimum time requirement in position:

Graduate nurse or inactive nurse—6 to 18 months
Experienced nurse—probationary period

Requirements:

Acquires 5 contact hours annually
Current CPR certification

Position Description: Clinician II (Clinical Step II)

General Description:

The clinician II demonstrates proficiency in administering fundamentals of the nursing process. She contributes to the nursing assessment and the development of the nursing plan. The clinician II implements nursing measures as described in the care plan and participates in the evaluation of nursing care. Functioning under direct supervision of the supervisor, the clinician II shall be responsible for individual patients or an entire patient population.

Education:

Graduate of an accredited school of nursing. Must have BSN and 2 years of nursing experience *or* non-BSN with 5 years nursing experience

Experience:

Promotion to clinician II—must have 18 months of experience
Hiring into clinician II—must have 18 months of experience with six months in a comparable position

Employment Status

Must work full-time

Requirements:

Acquires 10 contact hours annually
Current CPR certification

Position Description: Clinician III (Clinical Step III)

General Description:

The Clinician III demonstrates proficiency in administering all components of the nursing process to individual patients or a group of patients. The clinician III functions under the direction of the head nurse and may provide clinical supervision of general staff and clinician II nurses and of nonprofessional and paraprofessional staff. The clinician III participates in nursing or multidisciplinary committees and projects in the planning and evaluation of nursing care.

Education:

Graduate of an accredited school of nursing. BSN and 5 years nursing experience *or* certification and 8 years experiance required

Experience:

Promotion to clinician III—three years in nursing required
Hiring into clinician III—three years of nursing with recent experience in comparable clinician III position
Must have a minimum of 2 years experience in specialty

Employment Status:

Must work full-time

Requirements:

Acquires 15 contact hours annually
Current CPR certification

Position Description: Clinical Specialist

General Description:

The clinical specialist demonstrates advanced proficiency in administering the nursing process and serves as a clinical resource person to other members of the nursing staff in administering the nursing process. The clinical specialist shares responsibility for program development with other nursing leaders and supervises the delivery of care for a defined patient population. The clinical specialist chairs nursing committees, designs and directs nursing projects or research evaluation activities, and represents the department of nursing in hospital or community affairs.

Education:

Graduate of an accredited school of nursing. Master's degree in nursing

Experience:

5 years nursing experience (minimum 2 to 3 years in specialty)

Employment Status:

Full-time preferred

Responsible to:

Coordinator for division

Requirements:

Acquires 15 contact hours annually

Table 7. Guidelines for clinical ladder

1. All new hires must be no higher than clinical step 1. A minimum of four months hospital employment is required before promotion to an advanced ladder level. The Clinical Assessment Promotion Committee will look for evidence that the candidate meets some criteria for the advanced ladder position.
2. No advancement within the clinical ladder can occur without a Clinical Promotion Assessment Committee recommendation.
3. A nurse may apply for an advancement on a comparable unit.
4. If an opening occurs in an area in which the nurse is not currently employed and experience requirements are met, the nurse may maintain her current level for a three-month period. At the end of three months, a performance evaluation is completed. Results of the performance evaluation will determine if the individual retains current position or is reclassified to a lower level.
5. No minimal time need be spent at any level as long as experience requirements are met. However, candidates for promotion must clearly demonstrate that they consistently meet criteria for their current level before promotion will be considered.
6. Jumping or "skipping" levels is not prohibited, as long as the candidate demonstrates that she or he consistently meets criteria for the current level.
7. Candidates for advancement must have a discipline-free record for a minimum of one year before requesting advancement (that is, written disciplinary actions).
8. Yearly evaluations are to be completed by supervisors on nurses at all levels. If an individual's practice does not meet specified criteria, a written record of deficiencies is to be made. If, after four months, the individual does not demonstrate satisfactory performance of all criteria, she or he is reclassified to a lower level.
9. If a nurse is turned down for an advanced position because criteria are not met, the Clinical Ladder Promotion Committee will recommend a "Growth Plan," specifying recommendations for eliminating deficits as well as a time period before reapplication can be made.
10. Grievances regarding reclassification to a lower level are to first be referred to Clinical Ladder Promotion Committee for review and recommendation. If the nurse is not satisfied with the recommendation of this group, the specified hospital grievance process can be initiated.

The Clinical Promotion Assessment Committee should be a standing committee of the nursing service department. Its purpose is to review and recommend professional nurse candidates for advancement on the clinical ladder. The committee should be responsible to the director of nursing for making promotion recommendations.

It is suggested that the committee be composed of one staff nurse, two members of nursing management, one nursing education instructor, and a clinical expert (clinical nurse associate and, later, a clinical specialist). To qualify for committee membership, the person must possess knowledge of evaluation and be able to make objective decisions. The committee responsibilities are found in Table 5 as a sample for consideration.

Policies need to be defined regarding hiring into the ladder levels, promotion, demotion, and so forth. For example, some issues to be considered include the following:

1. The nurse must demonstrate a sustained level of excellence. Should she (or he) not continue to meet the level criteria, it will be necessary to demote that person to the appropriate level.
2. Should the committee deny promotion, the candidate may reapply at such time as she can provide the required evidence of sustained demonstrated practice that meets the level criteria.
3. Promotion can occur only when an advanced position is open.
4. A nurse may be hired into an open advanced position provided that the requirements of the position are met.
5. A nurse who transfers from one unit to another will maintain the performance level for three months, at the end of which time she will be reassessed for performance level on the new unit.
6. The promotion to a higher level, with the accompanying salary increase, will in no way affect the longevity raise due the employee on her anniversary.
7. The candidate shall be responsible for initiating the request for promotion and will supply all of the required documentation supporting her performance level.

Table 6 outlines the clinical ladder levels and brief job descriptions developed for each level that will be used at the Greater Baltimore Medical Center, and Table 7 summarizes the guidelines. We have also developed job descriptions, weighted job analyses, and evaluation forms based on these descriptions.**

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Effective computer usage

DRGs: Reimbursing for nursing services

A nursing model for primary care practitioners

Developing a hospice

Teaching employed RNs

...sing educational programs

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washington focus

National Institute of Nursing Approved in House

On November 17, the House of Representatives approved an amendment to the National Institutes of Health reauthorization which would create a National Institute of Nursing. The amendment was sponsored by Representative Edward Madigan (R.-Illinois), who had approached the nursing community with the notion last summer. Many nursing leaders believe that such an institution would give nursing greater legitimacy and visibility as a scholarly profession pursuing research endeavors in the university setting. Negotiations are underway to secure a sponsor for the amendment in the Senate. Look for an analysis and update in next month's *Washington Focus*.

Health Cuts are Capitol Hill Priority

As this issue of *Nursing & Health Care* went to press, Congress was moving toward adjournment, struggling with a number of belt-tightening proposals in health programs.

Among these is a plan proposed by Senator Robert Dole (R.-Kansas), chairman of the Senate Finance Committee, to reduce Medicare spending by $2.5 billion over the next three years. Dole's package would raise the monthly premium for Part B and the deductible payments for beneficiaries. This plan contains proposals to limit the amount of tax-exempt employer-paid health insurance premiums and to place a six-month freeze on physician fees as well.

Also under consideration is a proposal by Senator Edward Kennedy (D.-Massachusetts) and Representative Richard Gephardt (D.-Missouri), which they claim would eliminate the Medicare deficit. Major provisions of the plan are: 1) inclusion of all third-party payers in the prospective payment system; 2) establishment of incentives for the use of other than acute care services; and 3) requirement that physicians accept the federally established Medicare rates for their services as payment in full.

Proposed physician fee limits have received strong opposition from the American Medical Association, and considerable concern exists over those proposals that would increase out-of-pocket expenses for Medicare patients. However, if budget cuts are not enacted in Medicare and other health programs, the Fiscal Year 1984 budget ceilings will be exceeded, thereby adding to the overall federal deficit.

Economic Equity Act Pending

Legislation to improve and strengthen the rights of women in the workplace and elsewhere was introduced earlier this year by Senator Kennedy and Representative Patricia Schroeder (D.-Colorado). These bills, S. 888 and H.R. 2090, entitled the Economic Equity Act, include a number of major reforms to the tax, pension, and insurance laws as they apply to women. The five principal sections of the legislation are 1) pension reform; 2) IRA modifications; 3) tax treatment of child care expenses; 4) nondiscrimination in insurance premiums; and 5) enforcement of child support orders.

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FY 1984 Appropriations Bill Signed

A bill that appropriates funds to the Department of Health and Human Services for FY 1984 was signed into law by President Reagan on October 31, 1983. Following are the funding levels included for nursing education and research along with FY 1983 levels and President Reagan's FY 1984 requests, for comparison:

	FY 1983 Continuing Resolution	President's Request	FY 1984 Appropriation
Advanced Nurse Training	$13.26	$1.2	$13.26
Nurse Practitioners	11.76	6.0	11.76
Special Projects	6.33	6.0	7.16
Traineeships	9.6	—	9.6
Research Grants	5.0	—	9.0
NRSAs	1.0	—	—
Loans	0.9	—	—
Loan Repayment	0.8	—	—
Nurse Anesthetists	—	—	0.4
	$48.65		$51.18

Nursing Input into AMA Policy Committee

NLN President-Elect Dr. Jacquelyn Kinder has represented the League on an American Medical Association advisory committee charged with developing a health policy agenda for the American people, which the AMA sees as the basis for a Congressional proposal.

Several work group sessions and hearings have been held, with diverse representation from the health field. In addition to the League, the American Nurses' Association and the American Association of Colleges of Nursing have represented nursing in the work groups. Testimony has been presented on such topics as biomedical research, health professions education, health resources, delivery mechanisms, and payment for service. Responsibility for managing patient care has proven to be a controversial issue, with participants consistently voicing opposition to the singling out of physicians as supraordinate to other members of the health care team.

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DRGs as a Power Base

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Nursing & HEALTH CARE

VOLUME 5, NUMBER 4 *APRIL 1984*

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Cover story: The advent of DRG-based prospective payment demands considerable management and fiscal sophistication on the part of the nurse administrator. In the article on page 196, veteran of the New Jersey DRG system Rosalinda Toth asserts that making savvy use of the management report is a crucial step for directors of nursing in working the system and controlling the destiny of their departments.

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Congruence Among Primary Nurses in Their Perception of Their Nursing Functions

GWEN MARRAM VAN SERVELLEN & CARL JOINER

What can be generalized about the nursing practice in hospitals claiming to have primary nursing? The answer is, to this date, obscure.

The nursing practices in one primary nursing system cannot be totally correlated with those in another system. This will always be the case, since the numerous variables affecting nursing practice cannot be completely controlled or accounted for. We cannot even be certain that very basic nursing functions are carried out similarly.

The following article discusses an important approach to clarifying the similarities and differences in primary nursing practices by reporting the results of a study of primary nurses' perceptions of their basic functions in four different hospitals.

Although beginning research and evaluation in the area of primary nursing have, for the most part, led to some generalizations about the effectiveness of the modality over others, it is premature to suggest that these positive outcomes are arrived at through exactly the same means.

Primary nursing, as defined by Marram Van Servellen, *et al.*, is a philosophy and mode of organizing the delivery of nursing care in the hospital and is distinctly different from other modalities [*1*]. The total care of an individual patient is the responsibility of one nurse, the primary nurse, who assesses, plans, and implements the patient's care when she is on duty. The goals of the primary nursing system are to provide continuous, comprehensive, coordinated, individualized, patient-centered care. The primary nurse accepts authority, autonomy, and accountability for the care of a small caseload of patients throughout their hospitalization. When the primary nurse is not on duty, an associate nurse (who may be an RN or LPN) gives total patient care to the primary nurse's patients. For the most part, evaluation research would suggest that hospitals differ in the degree to which a change is undertaken and that, under uncontrolled conditions, all hospitals would not practice a single change in the same way. We have every reason to believe that the adoption of primary nursing in hospitals, now over a decade old, would demonstrate this simple principle-of-change theory. That is to say, wide variation should exist.

Nonetheless, the issue of commonalities and differences in primary nursing practices has virtually gone unresearched. Multiple-hospital studies measuring either the process or outcome variance among primary nursing units are absent from the literature. Marram Van Servellen, in a mailed survey to 300 hospitals in the United States known to be practicing primary nursing, concluded that both commonalities and differences existed in the hospitals surveyed [*2*]. The researcher further explained that the definition of the role of the primary nurse, the presence of specific objectives for the unit, the presence of individualized care plans, and assessments as a permanent part of the chart seem to be areas of congruence among those hospitals surveyed. However, there were differences in hospitals as to the ratio of patients to staff, depending upon whether a primary, primary team, or modular system was employed. There were also differences among hospitals with regard to the role of the primary nurse on weekends, and whether a number of supplementary operations (for example, peer-review, problem-oriented recordings, and standardized care plans) were used. In addition, over half of the hospitals identified unique aspects of their operation, indicating further variation in practice.

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The Study

In an attempt to shed light on the variance or convergence in primary nursing practice, Marram Van Servellen, *et al.*, took a closer look at primary nurses' perceptions of seven basic nursing functions.* It was assumed that the basic philosophical and organizational premises of the primary nursing modality would produce a degree of congruence in primary nurses' perceptions of their functioning. For example, it was assumed that comprehensive, individualized patient care—objectives of the primary system—may result in high levels of importance assigned by nurses to such functions as providing emotional support and teaching. If these philosophical concepts were translated into practice imperatives (for example, one-to-one personalized care), we might also expect to see nurses spending a great deal of time fulfilling this role requirement with all of their patients. Likewise, it was assumed that, because these objectives are integral to the primary nursing system, primary nurses, across hospitals, would converge in their beliefs and perceptions of this function.

Secondly, it was assumed that a focus on patient-centered care, another important objective of primary nursing, would place unit management low in priority (in both importance and time spent) in the minds of primary nurses in general and that this might be an area of convergence for primary nurses. Because no research has been conducted to date that summarized the commalities and/or differences in primary nurses' perceptions of these basic functions across hospitals, there was little basis upon which to express these assumptions in hypothetical terms.

The study design was a descriptive design with comparative purpose. The null hypothesis was stated as such:

There will be no significant differences in primary nurses' perceptions of their functions across three different hospitals.

- The level of importance attributed to each function will be similar.
- The perceived time spent in completing each function will be similar.
- The perceived proportion of patients for which the function is completed will be similar.

Sample: Nursing staff from three hospitals made up the study's sample. Hospitals participating in the study shared the following commonalities:

- All of the hospitals serve as teaching-learning centers for schools of nursing and medicine.
- All of the hospitals were considered general service, acute care hospitals; extended care was not integral to the services rendered.
- All of the hospitals had been prac-

*This study was a subphase of a larger, comparative study measuring the relative cost-effectiveness of primary units in the hospitals described here.

Table 1. Sample: Staff Per Level on Each Unit.

		RNs	LPNs	Aides	Totals
Hospital A	Unit 1 (24-bed orthopedic unit)	16	3	2	21
	Unit 2 (33-bed medical-surgical unit)	13	0	4	17
Hospital B	Unit 3 (26-bed cardiorespiratory unit)	13	4	0	17
	Unit 4 (21-bed general medical unit)	13	4	0	17
Hospital C	Unit 5 (27-bed medical-surgical unit)	10	3	6	19

ticing primary nursing on their units a minimum of eight months.
- All of the hospitals ranged in size from 350 to 550 beds.
- All of the hospitals were accredited by the Joint Commission on Accreditation for Hospitals.

In addition, only those units were sampled whose staff were mostly licensed staff. In all instances, the primary nurse role was defined as that of care planner *and* total patient-care giver. In essence, the primary nurse planned, coordinated, and carried out care for a small caseload of patients, including completing an assessment, drawing up a care plan, and involving both patient and family in this care.

Table 1 depicts the breakdown of staff, by level, on each unit participating in the study.

Note that, in all instances, the sample of licensed personnel was at least 50 percent of the total staff; in four instances (units 1, 2, 3, and 4), licensed staff accounted for three-fourths or more of the entire staff.

Units ranged in bed capacity from 21 to 34 beds; all units rendered either medical-surgical or medical service.

Survey

The concept of nursing functions developed here was first tested and used by Scott, Dornbusch, and Smith in their research on organizational authority in hospitals and schools [*3*]. The questionnaire for this study was tested for content validity and reliability (test-retest) and has subsequently been administered to approximately 810 nurses in 10 different hospitals.

Nurses in this study were asked to identify the importance, time spent, and proportion of patients for which the function was performed, using a five-point Likert scale for importance and proportion of patients, as well as an interval scale (containing seven divisions) for time spent. The functions were described as such:

1. Carrying out doctors' orders: includes administering treatments and giving medications.
2. Unit management: includes all activities necessary to manage or coordinate patient care; for instance, supervising staff, ordering supplies, and scheduling tests.
3. Assisting patients to complete daily activities: includes assisting patients with eating, ambulating, and bathing.
4. Providing for physical comfort related to the nursing care plan: includes PRN medication and positioning.
5. Providing emotional support and teaching to the patient and family: includes listening to patients' fears and concerns and giving the patient and his family reassurance, as well as teaching self-care.
6. Record keeping: includes charting in nurses' notes, adding to the care plan, and recording a nursing assessment.
7. Observing and assessing the patient and his family: includes diagnosing and evaluating patient's and family's response to illness and hospitalization.

Data Analysis

The statistical test used to assess the degree of differences in nursing functions among the three hospitals was the median test [*4*]. The median test is used to determine whether several samples come from a given population with the same median. This test is an extension of the more widely used chi-squared test for contingency tables.

The median was chosen as an appropriate measure for several reasons. If the distribution is skewed, the median is a more appropriate measure than the arithmetic mean. Additionally, the median is a proper test when some of the response categories are open-ended, as is the case in this response for time spent on nursing functions. Lastly, there was a desire for some measure of central tendency to examine a typical or representative measure for the several aspects of the seven nursing functions.

The basic hypothesis of the median test is that all three samples have the same median, versus the alternative hypothesis that at least two of the samples have different medians. The concept of the test is that all the samples (three in this case) are combined and that a grand median is determined, which is a measure that is exceeded by half the observations.

For each of the 21 tests (seven nursing functions each for importance, time, and proportion of patients), a 2 × 4 contingency table was devised. The test statistics are calculated from the following formula:

$$T = \frac{N^2}{ab} \sum_{i=1}^{3} \frac{0_{ij} - hja/N}{nj}$$

after obtaining the test statistic (T), a chi-squared table of values is used for the desired level of significance and degrees of freedom. In this application, a .05 level of significance was used, and 2 degrees of freedom (three samples less one) were appropriate.

Findings

Two measures of central tendency were employed in analyzing the results. Median responses of the sample in each hospital are presented in Tables 2, 3, and 4. The median is the value from the data set that measures the central item in the data. This item is the most central item and, as such, represents a measure of central tendency or commonality. Half of the items lie above the median and the other half lie below it.

One can see from Table 2—the perceived importance of nursing functions—that there are some differences in the majority's view of

these functions across all three hospitals. However, with the exception of unit management and record keeping, all other functions are deemed very or extremely important. Note that the rank order of these functions in each hospital depicts perfect convergence on only two functions: perceived importance of observing and assessing and perceived importance of assisting patients to complete daily care activities. The function providing emotional support and teaching was deemed very important in hospital A and extremely important in hospitals B and C, and unit management was rated moderately important in hospitals A and B and very important in hospital C.

In Table 3, greater variance in median responses arises in perceived time spent on these functions. Functions showing the greatest fluctuation in perceived time spent are unit management and assisting patients to complete daily activities, where time spent ranges from 1–2 hours to 3 hours. Note that the category providing emotional support and teaching is allotted 40–60 minutes in hospital A, 1–2 hours in hospital B, and 1 hour in hospital C. The only other function allotted the same time or less is observing and assessing the patient and his family.

In Table 4, depicting the proportion of patients for which the nurse performs a function, all or most categories are the median response pattern for all RNs across all functions. Note that perfect convergence exists with respect to the functions carrying out doctors' orders, unit management, record keeping, and observing and assessing. However, for the functions assisting patients to complete daily care, providing physical comfort, and providing emotional support, primary nurses differ in whether they administer to all or most patients.

Whereas the median is a basic measure of convergence in staff perceptions, a test of the differences using the median test described in the preceding section will indicate whether the differences or similarities are significant.

Although some variation is apparent in the average response of primary nurses in each institution, we need to examine whether significant differences exist. In order to reject the null hypothesis—that is, the notion that there is no significant difference in primary nurses' perceptions of their function—we would need a T statistic value equal to, or greater than, 5.99.

What Table 5 shows us is that none of the T scores is equal to or exceeds this value. Therefore, we would conclude, on the basis of this analysis, that primary nurses in all three hospitals perceive their basic functions equally. In more statistically related terms, the basic hypothesis cannot be rejected, and one would conclude, based on this research, that nurses' perceptions of the importance of, amount of time spent on, and proportion of patients involved in the seven identified functions are equal.

Table 2. Median Response on Degree of Importance/Rank Order of Nursing Functions.

Function	Hospital A	Hospital B	Hospital C
1. Carrying out doctor's orders	Very (2)	Extremely (1)	Very (2)
2. Unit management	Moderately (3)	Moderately (3)	Very (2)
3. Assisting patient to complete daily care activities	Very (2)	Very/Extremely*	Very (2)
4. Providing physical comfort	Very (2)	Extremely (1)	Extremely (1)
5. Providing emotional support and teaching to patient and family	Very (2)	Extremely (1)	Extremely (1)
6. Record keeping	Moderately/ Very* (3)	Very (2)	Very (2)
7. Observing and assessing the patient and his family	Extremely (1)	Extremely (1)	Extremely (1)

*For these entries, the median actually fell between the two adjoining classes.

Table 3. Median Response on Amount of Time Spent on Nursing Functions.

Function	Hospital A	Hospital B	Hospital C
1. Carrying out doctor's orders	1-2 hrs.	1-2 hrs.	3+ hrs.
2. Unit manager	1-2 hrs.	2-3 hrs.	3+ hrs.
3. Assisting patient to complete daily care activities	1-2 hrs.	2-3 hrs.	3+ hrs.
4. Providing physical comfort	1-2 hrs.	1-2 hrs.	1 hr.*
5. Providing emotional support and teaching to patient and family	40-60 min.	1-2 hrs.	1 hr.*
6. Record keeping	1-2 hrs.	1-2 hrs.	40-60 min.
7. Observing and assessing the patient and his family	40-60 min.	40-60 min.	40-60 min.

*For these entries, the median actually fell between the two adjoining classes.

Summary and Discussion

Variations among RNs in the three different hospitals were found to exist in their average (median) perception

Table 4. Median Response on Proportion of Patients for When Nursing Functions are Provided.

Function	Hospital		
	A	B	C
1. Carrying out doctor's orders	All	All	All
2. Unit management	Most	Most	Most
3. Assisting patient to complete daily care activities	Most	Most/All*	Most
4. Providing physical comfort	Most	All	All
5. Providing emotional support and teaching to patient and family	Most	All	Most
6. Record keeping	All	All	All
7. Observing and assessing the patient and his family	All	All	All

*For these entries, the median actually fell between the two adjoining classes.

Table 5. Results of Test Statistic for the Median Test.

	Function's Importance	Function's Time	Number of Patients
1. Carrying out doctor's orders	4.22	3.79	0
2. Unit management	1.35	4.16	3.08
3. Assisting patient	3.44	4.03	1.65
4. Providing for physical comfort	0	.54	0
5. Providing for emotional support	0	.40	3.5
6. Record keeping	2.13	2.30	0
7. Observing and assessing patient	0	.09	0

of their basic functions. Some variation appeared in the importance attributed to unit management and record keeping, while all other functions were either extremely or very important. Greater variation was apparent in primary nurses' perception of the time spent on these functions.

However, with the results of the median test, one should feel relatively comfortable in asserting that there are no significant differences in primary nurses' perceptions of their functions in these hospitals and that this fact transcends the dimensions of importance, time spent, and proportion of patients for whom the primary nurse completes the function.

This study was the first of its kind to compare the perceptions of primary nursing staff in multiple hospitals. A focus on nurse perceptions is one approach to a study of commonalities and of differences in nursing practice. The argument that perceptual assessments may be biased is hardly new or original. One is reminded, however, that perceptions also mold what one does and how one actually performs on the job and that, to some extent, perceptions are a statement of what occurs. In this case, one might conclude that nursing is practiced the same way in different primary nursing settings. Future research should address multiple means of establishing the variation and congruence in the functioning of primary nursing staff. This would include random-moment sampling of functions performed to assess actual time spent, as well as staff and patient perceptions of functions performed.

Additional research should also focus on the "why" of convergence and variance. With a larger sample size, the subtle relationships of staff role, type of (nurse) education, hospital objectives for primary nursing, specific organizational features, and hospital reinforcement for functions performed—obviously important intervening variables—can be more adequately discussed as they impact upon nurses' functioning and their perceptions of their activities.

This beginning study in establishing the similarities and differences among the perceptions of primary nursing staff of their work suggests that hospitals are practicing primary nursing—at least the basic nursing functions—similarly. There is not a wide variation across hospitals in primary nurses' perception of their activities and the importance of various functions.

This finding should be applied with caution, however. It is inaccurate to conclude that all primary nursing systems are the same. Whereas no significant differences were found in relation to these basic functions, the subtle operations—the "how"—may be quite different. Nurse administrators must be aware that the "how" as well as the "what" are important ingredients in producing outcomes. Whereas they can perceive some security in the fact that primary nursing staff may perceive their basic nursing functions similarly, it has yet to be shown that they practice primary nursing alike. Under these conditions, such desired outcomes as increased patient satisfaction and greater levels of individualized patient care associated with the adoption of primary nursing are not guaranteed to occur.

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Nursing & HEALTH CARE

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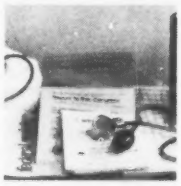

Cover story: Prospective payment has brought sweeping change to a health care delivery system already in transition due to technological advances, demographics, politics, and the economics of our increasingly complex health care industry. *Nursing & Health Care* explored the effects of current trends on nursing service with the chairpersons of NLN's Council of Community Health Services, Council of Nursing Service for Hospitals and Related Facilities, National Forum for Administrators of Nursing Services, and Committee on Long-Term Care. See page 312 for their thoughts on the present and future of nursing service in America.

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Official Publication of the National League for Nursing

WASHINGTON FOCUS

UPDATE: Nursing Education Funds, NIN, DRGs and Education

By Sally B. Solomon, MSN, RN
Director of Public Policy & Research, NLN

As this last issue of the 1983–84 *Nursing & Health Care* publishing cycle goes to press, the reauthorization bill for nursing education funding is making its way through Congress, and progress continues to be made on the legislative push to establish a National Institute of Nursing within the National Institutes of Health. Meanwhile, as the initial impact of prospective payment settles over the land, the question taking shape in the minds of many is what its implications will be for nursing education.

Nursing Education Funds

The Nursing Tri-Council (NLN, ANA, AACN) has been vigorously lobbying for legislation to reauthorize funding for nursing education. Last year, the Nurse Training Act (Title VIII of the Public Health Service Act) was authorized at $70.8 million; $43.1 million was appropriated for nursing education, in addition to the $10 million appropriated altogether for nursing research and research fellowships (Titles III and IV, respectively, of the Public Health Service Act). Development of this year's legislative initiative was guided by the recommendations of the Congressionally mandated Institute of Medicine (IOM) report, *Nursing Education: Public Policies and Private Actions*, which calls for an appropriations level of $80 million and stresses the need for nurses with graduate education.

The Senate nursing education measure, entitled the Nurse Education Amendments of 1984 (S2574), was introduced by Senator Orrin Hatch (R.-Utah), chair of the Senate Labor and Human Resources Committee. Senator Daniel Inouye (D.-Hawaii) cosponsored the bill, which in its original version authorized a funding level of $54 million. As a result of discussions between Senator Hatch's staff and the Nursing Tri-Council, the Senator amended the bill to raise the authorization level to $68.5 million. The legislation overwhelmingly passed in the Senate Labor and Human Resources Committee.

The bill stipulates that funding for nursing education programs and traineeships be targeted at the graduate level. It includes a new line item, demonstration projects, that would facilitate collaborative projects between nursing service and education, as well as cost-effective nursing innovations in health care delivery. Another new line item, fellowships, would provide funding for postdoctoral nursing studies in such areas as administration, education, and public policy.

An important feature of this bill is a provision to elevate the Division of Nursing to Bureau status and to create three subdivisions within the Bureau: a Division for Advanced Nurse Education, a Division for Nurse Educational Support, and a Center for Nursing Studies and Research.

The House of Representatives version, the Health Professions and Service Amendments of 1984 (HR5602), was drafted by Congressman Henry Waxman (D.-California). The bill originally authorized $63 million for nursing education. Congressman Waxman subsequently agreed to increase the funding to $71 million, the level approved by the Energy and Commerce Committee's Subcommittee on Health and the Environment, which he chairs.

On May 15, the revised HR5602 was sent to the full Energy and Commerce Committee. Lobbying efforts by the Nursing Tri-Council generated an amendment, sponsored by Congressman Matthew Rinaldo (R.-New Jersey) and Congressman James Florio (D.-New Jersey), increasing the authorization level to $76 million. With Congressman Waxman's strong endorsement, this bill was passed by the full Committee.

As with the Senate bill, the House legislation emphasizes graduate nursing education and includes a section on demonstration projects, but it does not include fellowships. Nor did the House, which has already passed legislation to create a National Institute of Nursing, provide for a nursing research center.

It is anticipated that both bills (S2574 and HR5602) will be passed and referred to a Joint Senate/House Conference Committee, where a compromise version will be developed. Funding levels are currently under consideration in the Appropriations Committees.

In the interim, readers are urged to contact their Senators and Congressmen in support of the respective bills. Special attention should be directed to the Appropriations Committees in both the Senate and the House, since this is where final decisions about allocation of funding will be determined.

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Overview of Funding for Nursing Education
(in millions of dollars)

	FY 1984 Authorizations	FY 1984* Appropriations	FY '85 Authorizations S2574	HR5602
Special Projects	11.0	7.2	10.0	12.0
Advanced Nurse Training	16.0	13.3	17.5	21.0
Nurse Practitioner	14.0	11.8	12.0	19.0
Traineeships	11.0	9.6	12.0	15.0
Nurse Anesthetists	0.8	1.0	1.0	1.0
Student Loan	18.0	0.0	1.0	0.0
Demonstration Projects	not authorized		5.0	8.0
Fellowships	not authorized		3.0	0.0
Bureau of Nursing	not authorized		2.0	0.0
Center for Nursing Studies and Research	not authorized		5.0	0.0
Total	70.8	43.1	68.5	76.0

*In addition, $9 million was appropriated for nursing research under Title III of the Public Health Service Act, and $1 million for nursing research fellowships under Title IV.

National Institute of Nursing

The proposal to create a National Institute of Nursing (NIN) within the National Institutes of Health (NIH) was passed by the House of Representatives last November as an amendment to the NIH reauthorization bill (HR2350). Congressman Edward Madigan (R.-Illinois) sponsored the legislation, based on the IOM recommendation that nursing research receive more visibility on the federal level. (See "Washington Focus," February 1984.)

Although Senator Hatch, whose Labor and Human Resources Committee has jurisdiction over NIH, was not persuaded to sponsor a NIN, senatorial support for the NIN came from longtime friend of nursing Senator Inouye, who circulated a "Dear Colleague" letter enlisting endorsement of a NIN. Four other senators signed onto the letter, including two members of the Labor and Human Resources Committee—Senators Paula Hawkins (R.-Florida) and Robert Stafford (R.-Vermont)—as well as Senators Thad Cochren (R-Mississippi), and Spark Matsunaga (D.-Hawaii). Senator Inouye has drafted a bill proposing establishment of a NIN, which he plans to introduce in the Senate.

As mentioned above, the Senate bill to reauthorize funding for nursing education includes provision for creation of a Center for Nursing Studies and Research, housed within a newly formed Bureau of Nursing. The Center would coordinate and disseminate information regarding nursing research throughout the federal government. It would also be responsible for administration and awarding of research funds under sections 472 and 301 of the Public Health Service Act, although funding for the Center itself would be completely independent of funding for these sections. The intent of this legislation is to raise the status of nursing research, and it is viewed by many as a step toward a National Institute of Nursing.

The Nursing Tri-Council believes that a Center for Nursing Studies and Research could enhance nursing research, but should not be viewed as a substitute for or alternative to a NIN. We advocate the formation of a NIN and endorse Senator Inouye's initiatives in this regard.

DRGs and Nursing Education

The enactment of prospective payment legislation and the threatened insolvency of the Medicare trust fund have raised questions regarding the extent to which the federal government should be involved in financing education for the health professions—especially through Medicare.

Hospitals historically have factored student costs into their rates; Medicare, like all payers, has shared in reimbursing these costs. The original intent of Medicare's reimbursement of health professions education was to help carry these costs until they could be financed more extensively by other sources in the private and public sectors.

Under the new prospective payment system, such direct educational costs as salaries, classroom space, educational materials, and overhead are "passed through," i.e. reimbursed on a reasonable cost basis. For nursing, these costs are mostly attributed to diploma programs, which are more directly accounted for in a hospital's budget because of their structural ties to the hospital. Financial arrangements between other types of nursing education programs and hospitals used for clinical placements have been inconsistent, with variations extending to cost reporting. Conclusions as to total costs of nursing education under Medicare are estimates at best, and more research is needed before policy changes can be made.

Prospective payment also includes an indirect educational adjustment for hospitals with medical teaching programs. This allowance is not meant to be a precise measurement of costs incurred, but rather a recognition of the higher costs involved in a teaching facility, including the costs of other health professions education, such as nursing.

It has been predicted that if Medicare reimbursement for all health professions education were withdrawn, beginning in 1987, the total program savings through 1995 could reach $40 billion. The Social Security Advisory Council has suggested that the government discontinue the financing of health professions education through Medicare. However, it is not recommending that funding be immediately curtailed without sound alternatives in place. One alternative is to fund these educational costs through block grants to states or regions.

For nursing, this means that we must heed the signals of the changing times and be prepared in two respects. First, we need to document more carefully the financial arrangements between educational and service agencies. Second, we should maintain an active role alongside government officials and other health care professions in resolving the issue of federal financing of health professions education.

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Cherchez les Femmes

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Nursing & HEALTH CARE

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Cover story: With the impact of the landmark nomination of a woman for vice-president and the impact of the much discussed gender gap eluding political observers, this is truly an election year in which to *"look for the women."* The significance for nursing becomes evident when one considers that one in 44 registered women voters who is a nurse. This month's "Washington Focus," on pages 370 and 371, examines the parties' records and the candidates' stands, paying special attention to health care issues.

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Official Publication of the National League for Nursing

Graduate Education in Gerontological Nursing Revisited

H. TERRI BROWER

Graduate education assists in defining the scope and nature of nursing specialties. The need for a gerontological nursing major existed long before its development in the late 1970s. Although the first program was initiated in 1966, the real thrust came later.

Background

An initial study in 1976 of graduate programs in gerontological nursing indicated that there was wide variety in the eight functioning graduate programs, as well as indications of a lack of faculty expertise or a lack of emphasis on the major in some programs. Enrollment at that time, while small at an average of 10 students, was attributed to factors due to the novelty of the major, negative attitudes that nurses hold toward the aged, marketability of graduates, and the presence or absence of a visible gerontological focus in the larger university [*1*].

In 1980, the American Association of Colleges of Nursing identified 18 graduate programs in gerontological nursing that were accredited. Although no figures were provided on graduates or student enrollment in the programs, its prepared statement to a House of Representatives' subcommittee said: "they are reported to be attracting more students than the older, more traditional, majors" [*2*].

The number of programs had increased substantially, as reported by the Department of Health and Human Services, Division of Nursing. In 1981, the Division noted that 47 of some 70 federally supported advanced nurse training programs and nurse practitioner training programs "had substantive geriatric content" [*3*]. However, only 23 programs were considered to be addressing the broad social issues of gerontology. The Division also noted that the government does not "pass on quality issues" related to curriculum content or on major or minor status.

Aspects considered essential by many gerontological leaders for a program in gerontological nursing include curriculum organization and content, presence of active research on aging, and faculty expertise [*4–6*]. In addition, there are quantitative aspects that concern numbers of students, programs, and graduates.

The nature of gerontological nursing requires a multidisciplinary focus in order to prepare leaders who will have a broad theoretical framework. This requires the availability of courses on aging, as well as aging activities and research in the larger universities. Through the use of electives or cognates, students should be able to take courses in aging taught by departments other than nursing. While many universities have undergraduate gerontological courses, very few courses exist at the graduate level, and those that have graduate courses often have limited offerings.

Curriculum content within the nursing major should reveal the ability of the program to prepare future leaders in gerontological nursing. The long-term health care sector is perhaps the one in most dire need of leadership to create positive change. The extent of this need is illustrated by numerous statistical reports. The population that resides in nursing homes is comprised of more women and of increasingly sicker, and older, people, with 95 percent now requiring some help with activities of daily living [*7*]. It is appropriate to identify how graduate programs are responding to the challenge of this problem. Additionally, there are several important works that can serve to provide direction for designing graduate gerontological nursing curriculums.

Gunter and Estes have developed a comprehensive curriculum guide that covers content from the level of the nursing assistant to the doctorally

H. Terri Brower, EdD, RN, FAAN, is a professor of gerontological nursing at the University of Miami Schools of Nursing and Medicine, Miami Springs, Florida. This study was supported by a DHHS PHS HRA BHM Division of Nursing Nurse Practitioner Section grant, No. 1 D24 NUOO157.

*Table 1. Quality Indicators in the Curriculum of Gerontological Nursing Majors.**

	Schools Requiring 24–36 Credits to Complete MSN		Schools Requiring 37–60 Credits to Complete MSN		Schools Offering a Minor	
	No.	%	No.	%	No.	%
Require gerontology cognates	3	38	5	29	6	50
Permit electives	7	88	15	88	12	100
Require a long-term care course	2	25	5	29	5	42
Provide advanced assessment skills	6	75	15	88	10	83
Total schools	8 schools		17 schools		12 schools	

*Calculated only for schools supplying adequate information.

prepared nurse [*8*]. Their text includes level objectives and offers philosophical background and practical suggestions for faculty. Another work, although directed specifically at the baccalaureate level, is a critical one to review when designing graduate curriculums. Developed as a result of a joint Delphi research project, both content topics and nursing skills were identified. The study was performed jointly by the Gerontological Society of America and the American Association of Gerontology in Higher Education, although few nurses were invited to participate in the study [*9*]. Additionally, Brower has developed a conceptual framework with sample content considerations that can be helpful to both undergraduate and graduate curriculum designers [*10*].

The Survey

In order to determine the current state of a graduate program in gerontological nursing, a survey was conducted in the spring of 1982. Questionnaires were sent to all of those programs identified as having a major, subspecialty, or track in gerontological nursing [*1*]. Questionnaires were also sent to programs identified by DHHS's Division of Nursing's Nurse Practitioner Program and Advanced Nurse Training sections, and to others known to the author. Fifty-one questionnaires were distributed.

Responses

There were 47 respondents, for a response rate of 92 percent. Twenty-eight programs had a functioning major in gerontological nursing, and 7 were in planning stages, of which 2 identified that they were going to offer a major. (Not queried were 2 other programs that were planning the major, raising the total to over 32 identified as offering the major as of fall, 1983.) Seventeen respondents were offering a minor, and 5 offered both the major and minor. Two programs previously offering a major no longer offered it, of which one of these was dropped to a minor. Another program had a hiatus during which the gerontological major was not offered for two years due to the vacancy left by the key faculty person. Included now are 2 programs focusing on geropsychiatry, one offering a major, and the other, a minor.

In an effort to determine the nature of curriculums taught for the gerontological major, questions were asked concerning total number of credits, core nursing credits, gerontological cognates, presence of electives, existence of advanced assessments skills, and whether a long-term care course was taught. Some respondents did not answer all of the questions, and computations are based on those who did respond. The total number of credits in order to complete the MSN ranged from 24 to 60 credits; all credits were converted to semester hours.

Ten schools reported requiring between 24 and 36 hours, and 25 reported requiring 37 to 60 hours for completion of the degree (see Table 1). Schools requiring a greater number of credits tended to have a course in long-term care and to offer assessment skills, cognates, and electives, whereas schools having 36 or fewer credits tended to offer less.

Data were computed to ascertain the strength of the major by subtracting the number of core nursing credits, cognate credits, and elective credits. The amount of credits available for the major indicate the percentage of time that the student will be able to focus on the nursing major, which would be strengthened by the presence of gerontological cognates and/or electives. Credits available to focus on the major ranged from a low of 5 to a high of 45 nursing credits. Six programs had 16 or fewer credits in the major and, of these, three required cognates, indicating that the three remaining programs offering the major have exceptionally limited time allocated to the specialty. Seven programs had 18 to 25 credits in the major, with two of these requiring cognates. Only four programs had 27 to 45 credits in the major, with *none* of these offering cognates in gerontology. Extremes were reflected in two programs showing 45 credits and 5 credits, respectively, in the major. Both of these offer no cognates, one elective, and no course in long-term care, reflecting a limited focus in the major despite wide disparity in terms of required credit load.

In order to determine whether students were having difficulty attending school in light of reductions in traineeship monies, an effort was made to determine those students who were employed full time. There were no questions regarding part-time employment. Seven schools reported no enrolled students employed full time. Five reported between 10 and 49 percent working, four reported between 50 and 75 percent working, and three had between 80 and 100 percent of students working full time. One school reported 100 percent of students working, with none being able to maintain full-time study and full-time work combined. Table 2 shows the number of private and state schools reporting the percentage of

students on traineeships and the percentage working full-time (not all schools identified themselves in this category, and these were not included in certain comparisons). The availability of traineeships and whether the school was state or private had an effect on whether students worked full-time, with more private school students working whether or not they were able to obtain some traineeship support.

Student enrollment was analyzed in a number of ways. Full-time and part-time students were determined according to regions. Notably, no program having a major was found in the Mid-Central or Midwest regions (see Table 3). Using Chi Square statistics, there was a significant relationship ($<.0005$ level) between part-time and full-time enrollments and region. The Western region had more enrolled full-time students than expected, with 49 enrolled compared to the expected 32.1. The North-Central had fewer students enrolled (14) than the expected (39.1). Likewise, it can be seen that, in these two regions, the West had fewer part-time students, while the North-Central had far greater numbers of part-time students enrolled than expected. The Northeast had the greatest number of full-time students (one school from the Northeast, reporting only two students, was not included in the data analysis due to lateness of response), while the North-Central reported the smallest percentage of full-time students.

The effects of funding on student enrollment were analyzed for all schools, comparing those programs having no funds, those with five or fewer years of funding, and those with more than five years of funding (see Table 4). As can be seen, funding has a very significant effect on student enrollment. One nonfunded program, the first in the nation, had been in operation for 16 years, yet had only seven full-time students, while another nonfunded program, in operation for nine years, had only two full-time students. Six schools in operation six or more years reported having seven or fewer students enrolled full-time in the gerontological major.

Of all the programs offering the major, only four were not experiencing recruitment difficulties. Two of these four respondents qualified their status with such statements as, "We work at it all the time," and, "We have constant recruitment efforts; we expect difficulties in the near future." The rest of the respondents, *all* of whom identified difficulty with recruitment, were asked to speculate on the future of the major at their school. Ten responded that there was a commitment to continue, six responded that they were studying the issue or were unsure, and six said that the future of the major was limited or doomed. Word of mouth was noted to be the most significant recruitment measure, with brochures and public announcements adding additional help.

Table 2. Relationship of Student Employment to Traineeship Support.

State			Private		
No. of Schools	% Working Full-Time	% on some Traineeship Support	No. of Schools	% Working Full-Time	% on some Traineeship Support
3	0	100	1	10	100
1	0	50	1	0	75
			1	0	0
1	50	NA	1	10	100
1	50	50	1	10	90
1	80	NA	1	25	75
			2	100	100
			1	100	25
Totals: 7 schools			9 schools		

Table 3. Regional Distribution of Full- and Part-Time Students.

Full-time students	South	Northeast	West	North Central
Actual	34	55	49	14
Expected	34.7	49.1	32.1	39.1
Part-time students				
Actual	21	23	2	48
Expected	20.4	28.9	18.9	22.9
$X^2 = 69.55$	$p < 0.005$		df = 3	N = 254

Table 4. Student Enrollment for State and Private Institutions.*

Private	South	North East	West	North Central
Actual	20	25	0	12
Expected	14.8	19.4	17.2	5.6
State				
Actual	22	30	49	4
Expected	27.2	35.7	31.8	10.4
$X^2 = 74.6$	$p < 0.005$		df = 3	N = 162

Major Concerns

In addition to being plagued by small numbers of students and recruitment difficulties, respondents were queried as to their specific concerns for gerontological nursing. The primary concerns most frequently cited by 11 respondents were: a) motivating and stimulating interest in the major; b) the viability of the major as the priority concern; and c) position opportunities for graduates and salary compensation commensurate with qualifications and preparation. The second-most-voiced concern of eight

respondents was the difficulty of securing doctorally-prepared faculty with expertise in gerontological nursing. Four respondents saw the lack of scholarships or traineeships as a deterrent to programmatic development, whereas three cited inadequate undergraduate preparation as a problem.

Quality of applicants was also addressed. One respondent noted that three of the five applicants admitted to the major for the 1982–83 year were admitted on probation because of inability to meet entrance qualifications and further stated that other majors were rarely in a position in which they had to lower their admission qualifications. Two respondents voiced concerns that the program lacked sufficient depth and that the quality of the curriculum suffered, and several noted that assessment skills were not sufficiently applied. One was concerned over the lack of a long-term (secondary health care) focus in the program. One noted that national acceptance by nursing deans of gerontological nursing as a bona fide specialty was essential for success.

Discussion and Implications

This review suggests that the total number of credits available for the major is no indication of whether other qualitative aspects, such as cognates and a course in long-term care, are included. The dearth of courses in long-term care in programs espousing to teach the major is disturbing. By neglecting to include a long-term care focus, graduate gerontological educators may be unwittingly perpetuating the myth that there is nothing to learn in the nursing home setting. However, since graduates will be called on to consult or teach staff in nursing homes and, in some instances, to work in nursing homes, such an immensely critical component of care should be included.

There are several points to consider when discussing disparities: A number of programs are being initiated where there are none-to-limited numbers of graduate-level courses in gerontology available in the larger university. In some programs, other constraints are present, such as the increased movement toward core nursing curriculum, thereby weakening the specialty. Some programs have been planned and started by those who have little expertise or academic preparation in gerontological nursing.

The timing of the onset of the major is a critical determinant in the evolving specialty in gerontological nursing. Furthermore, because the need was so pressing, the major was initiated before adequate content in gerontological nursing had been integrated into undergraduate curricula. The major was initiated in many schools prior to the availability of gerontological nursing texts. Additionally, research in gerontological nursing has been limited, resulting in poorly identified content or content that lacked a firm grounding in nursing science. Therefore, an add-on approach to content by faculty lacking knowledge may have occurred in a number of programs. While there will continue to be content overlap between educational levels, the reluctance of undergraduate faculty to include gerontological nursing content continues to compound this problem.

Curriculum content within the nursing major should reveal the ability of the program to prepare future leaders in gerontological nursing.

Recruitment problems have resulted in many programs offering a minor instead of a major. But a minor is not a strong-enough focus to prepare the type of practitioners needed for education and practice. However, those who have had the opportunity to study in the minor may have had their appetites whetted sufficiently to choose a doctoral focus in gerontological nursing if they return to advanced study. Programs offering both the major and minor are needed. Schools that have sufficiently flexible curricular structures already offering the major should consider the addition of minors. Those programs that have achieved considerable success in the minor should plan expansion into offering the major, as well.

The defensive stance, as evidenced by denial of problems and inflated student enrollment by 10 respondents, does not allow clear identification of the problems. Unless faculty keep the problems in focus, there will be less done to identify solutions and strategies for alleviating recruitment problems. Leaders need to consolidate activities in order to enhance recruitment. A case can be made for legislation to prioritize traineeships for students to study in the specialty. Such initiatives could do a great deal toward overcoming the reluctance of nurses to study in the major.

It is interesting to note that advanced nurse traineeship monies were prioritized for nurse midwifery students in the Omnibus Reconciliation Act of 1981. The DHHS Division of Nursing interpreted this rule by giving increased amounts of traineeships to schools having midwifery programs. But some schools of nursing having both gerontological nursing and midwifery students further interpreted the rule to prioritize award monies to midwifery students. Nurse midwifery programs have no difficulty in obtaining students; instead, they have a two- to three-year waiting list and three to five applicants or more for each student admitted. This highly-sought-after major also has activist faculty and practitioners who are effective in lobbying for their cause.

Unfortunately, dwindling traineeship monies in most schools no longer cover even tuition costs, as they are divided up among eligible applicants. Private schools, because of high tuition, and the depressed North-Central region seem to have the most difficulty with students working full-time. Although two private schools indicated that 100 percent of their students received some traineeship monies, 100 percent of their students also worked full-time. Full-time employment while attending school full-time severely compromises learning ability. There is greater available traineeship support for the geropsychiatry majors, yet there were only one major (now there are two) and one minor identified with this focus. Additionally, the Veterans Administration has recently allocated a small amount of money to be used for a limited number of graduate nurse traineeships. However, in spite of the reality that the VA health care system in-

creasingly faces the problems of caring for an aging veteran group, there was no attempt to make traineeships for graduate gerontological nursing study a priority.

The source of funding for programs can contribute to programmatic problems. Funded faculty lines from the Division of Nursing's Nurse Practitioner Section are permitted to teach only the specific content related to practitioner preparation and the major. When student enrollment was small, pressures on faculty to teach in other courses caused problems for faculty and project directors and resulted in reduced funding because of the small student numbers. This can result in demoralization and loss of key faculty persons. Furthermore, nurse practitioner funding rules and regulations were originally promulgated with continuing education programs in mind. A change in nurse practitioner funding regulation is indicated to more appropriately reflect the reality of part-time graduate student enrollment, since an increasing number of graduate gerontological programs is funded through this source and is unable to meet the current unrealistic student enrollment figures.

How long should programs receive federal funding to the exclusion of developing other programs? Four programs have received federal funds for 7, 8, 9, and 10 consecutive years. However, only two of these programs, both state schools, can be considered to have good student enrollment (the 9- and 10-year funded programs). The remaining two schools were private and continue to have low student enrollment. Whether or not programs are able to increase enrollment after five years of continuation of funding should be questioned by legislators, in view of tightening fiscal controls.

Although the lack of undergraduate preparation in gerontological nursing accounts for some of the recruitment difficulties, other factors can also be attributed. Nurses' attitudes toward aging, especially a number of those who work with the elderly have been found to be less than positive [*12–14*]. Turning around ageism is a monumental task that can only be affected by the constant sensitization of those harboring such views. Although increasing numbers of nursing leaders acknowledge the need for gerontological nursing education, both graduate and undergraduate, this has not resulted in adequate inclusion of such content in nursing programs. Greater nursing leadership in both the service and academic sectors is required to combat this problem.

Graduates of the new programs will be expected to assist in creating positive change. Gerontological nursing clinical specialists, role models in the service areas, can assist nurses by correcting stereotypes and by increasing knowledge in gerontological nursing. The clinical specialist is capable of consulting with others about the care, as well as demonstrating expert care, of the aged. The specialist can plan appropriate educational programs about aging on an ongoing basis for both staff and significant others. Service leaders can provide incentives for nurses to choose study in the field. They could begin by providing salary initiatives, offering a differential higher than those provided for specialties for which more clinical specialists are available.

Turning around ageism is a monumental task that can only be affected by the constant sensitization of those harboring such views.

Graduate gerontological nursing programs will continue to expand. Planners of such programs are encouraged to examine all of the variables that go into creating a superb offering. Recruitment and feasibility studies for interest in gerontological nursing, and position availability upon graduation, can greatly refine the planning process. Dean Valerie Prock has said that in order to produce viable leadership and programmatic development, a school should possess at least three faculty members who have expertise in gerontological nursing [*15*]. This is salient advice for planners.

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Nursing & HEALTH CARE

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Cover story: Democratic Vice-Presidential nominee Geraldine Ferraro (cover, center) has been the focus of attention in this year's political race to win the women's vote. The Republicans also attempted to bridge the gender gap at their convention, which featured U.S. Treasurer Katherine Ortega (upper left) as keynoter and highlighted (clockwise from upper right) Health and Human Services Secretary Margaret Heckler, U.N. Ambassador Jeane Kirkpatrick, and Transportation Secretary Elizabeth Dole. This month's "Washington Focus," on pages 420-421, ponders the lesson to be learned from this ardent display of gender politics.

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The Use of Graduate Assistants in Nursing Education

ALOISE ANNE ZASOWSKA
&
LILLIAN C. SOLOMON

Graduate students have long been temporary members of the instructional personnel in American higher education. Over the years, in disciplines other than nursing, countless numbers of graduate students have been socialized into the teaching profession and/or have supported themselves through school by serving as teaching assistants (TAs) or research assistants (RAs) [*1–2*].

Literature pertaining to the use of graduate students as graduate assistants in American higher education deals with the origin and history of the TA System, the responsibilities and functions of TAs, views regarding the use of TAs in undergraduate education, and orientation and in-service education programs for TAs [*1–13*]. However, the literature focuses on the use of TAs and RAs in nonnursing disciplines. Notably, a majority of the research on this subject was conducted prior to this decade.

Because it is a known fact that graduate nursing students serve as TAs/RAs in some schools of nursing, the extent and scope of this practice posed an interesting area for investigation. Since the literature provided no evidence regarding graduate nursing students serving as graduate assistants (GAs), a national survey was undertaken, with a two-fold purpose:

1. To identify the extent to which graduate nursing students serve as graduate assistants in nursing education programs, and
2. to identify the selection criteria, functions and responsibilities, and financial rewards of graduate assistants in nursing education programs in which graduate nursing students serve in this capacity.

Survey Methods

Eighty NLN-accredited graduate nursing programs were included in this national survey. The chief administrative officer was invited to participate in the national survey either by personnally completing a self-administered mail questionnaire or by having the chairperson of the graduate program complete the instrument.

The instrument itself, developed by the investigators, contained 12 questions that addressed seven dimensions of the graduate assistantship: 1) use/nonuse of GAs; 2) criteria for selection; 3) roles and responsibilities; 4) length and hours of service; 5) financial rewards; 6) institutional policies; and 7) faculty beliefs regarding the use of GAs. Survey items were formulated following a review of the literature and interviews with two chief administrative officers who were familiar with graduate assistantships in nursing education.

Results

Sixty-seven graduate nursing programs (83.7 percent) responded to the survey. The 13 programs (16.3 percent) from which no response was received were geographically dispersed throughout the country.

Use of Graduate Assistants. Of the 67 respondents, 70 percent (47) indicated that graduate nursing students served as GAs in several capacities, while the remaining 30

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percent (20) stated that they did not have GAs. Among the programs providing assistantships, 15 percent (7) reported that only doctoral students held appointments of this nature.

The respondents noted that graduate students served as graduate assistants (GAs), teaching assistants (TAs), research assistants (RAs), and project assistants (PAs). In most instances (65 percent), a student at any level in the graduate program was eligible to apply for an assistantship. However, several respondents (33 percent) did identify a particular level as a prerequisite for application—for example, completion of two to three semesters in the graduate program (3), completion of three to four quarters in the graduate program (2), enrollment in the doctoral program (7), or completion of a course in curriculum and instruction (1). One respondent pointed out that the area of the assignment in the educational program determined the prerequisite level of the student.

Criteria for Selection. The 47 nursing schools that indicated that GAs were integrally involved in the nursing program listed several criteria that were used in the selection of the assistant. In most cases, a combination of criteria guided the selection process. Only one school reported that it had no specific criteria for selection. Table 1 presents the list of criteria reported by the respondents and the number of schools of nursing using each criterion.

Roles and Responsibilities. In describing the capacity in which GAs served their programs, the respondents identified clinical teaching, laboratory instruction, and faculty research as the three major areas in which GAs functioned. A majority of the respondents (72 percent) noted that GAs engaged in clinical teaching under the supervision of a faculty mentor; or, as reported by many programs (65 percent), they also provided instruction in the nursing laboratory on the college campus. In 63 percent of the programs, graduate students functioning as RAs assisted faculty with their research by carrying out such activities as library searches, literature reviews, and/or data collection.

With respect to the programs in which GAs provided classroom instruction (61 percent), most of the respondents (79 percent) described involvement in this area as "assisting only"; the remaining (21 percent) explained that full responsibility for selected classes was given only to the GAs who were doctoral students. In the 28 programs in which GAs engaged in classroom instruction, 56 percent of the respondents noted that GAs also assisted with grading and evaluation (primarily quizzes and examinations). Only 15 percent of these schools had GAs participating in the development of course outlines.

Addressing instructional responsibilities, approximately two-thirds of the respondents (32) indicated that GAs attended course meetings, but only about one-third (15) stated that GAs were present at faculty meetings. In only a few schools (4) did GAs serve on committees.

In general, whatever the number of assistantships a school might have, it seemed to be a common practice among a majority of the programs (35) to have a few GAs serving as TAs and a few functioning as RAs.

Length and Hours of Service. No one particular policy governing the length of service or the weekly time commitment for the assistantship was evident from the responses. Of the 47 respondents, 15 (32 percent) stated that graduate students were given this position for two semesters; 4 (9 percent) noted that assistantships extended over four semesters; and another 4 (9 percent) indicated that awards were made on a semester basis. An additional 6 respondents (13 percent) reported no limits on the assistantship, while 3 (5 percent) explained that students could hold this position for the duration of their graduate program. The remaining participants (32 percent) pointed out that the duration of the appointment depended upon the needs of the school, the courses taught, and the student's program of study.

Of the schools reporting use of GAs, 82 percent (39) cited 10–20 hours per week as the required time commitment; 4 percent (2) gave a range of 4–30 hours; 2 percent (1) stated that GAs usually served 5 hours per week; and 6 percent (3) noted that the weekly time commitment "varies." Two programs did not respond to this question.

Financial Rewards. Of the 33 participants who elected to respond to items pertaining to financial compensation for services, everyone stated that GAs received a direct salary, and the majority (23) noted that GAs also were given a tuition waiver. Details of the tuition waiver were not explored.

The schools reported a wide range in the amount of the stipend. Where GAs were paid in terms of per-hour

Table 1. Criteria Used in Selection of Graduate Assistants and Number and Percentage of 47 Schools of Nursing Using Each Criterion.

Selection Criterion	Schools Using Criterion	
	No.	%
Experience in nursing practice	20	44.4
High academic achievement (e.g., GPA, GRE scores)	17	37.8
Prior teaching experience	18	40.0
Course in curriculum and instruction	6	13.3
Enrolled in doctoral program	7	15.6
Teaching, clinical, and research experience	3	6.7
Experience in area of school's needs	5	11.1
Interest/request by student	6	13.3
Recommendation by faculty	2	4.4
Matriculated graduate student	2	4.4
Applicant's philosophy is compatible with philosophy of undergraduate curriculum	1	2.2

services (11 schools), the award ranged from $5.00 to $10.00 per hour; the average was $7.50 per hour. One school engaging both TAs and RAs stated that RAs received a lower hourly payment. Another pointed out that "TAs with experience" were given a somewhat higher award. Where stipends were awarded on a monthly basis (4 schools), the salary ranged from $325 through $600 per month. Thirteen programs gave GAs an annual salary ranging from $2300 to $6000 for a nine- to ten-month academic year. A few schools (5) elected to omit the amount of the stipend.

Institutional Policies. Of schools reporting that they had graduate assistantships, only slightly more than one-half (26) indicated that they had specific guidelines governing the services of GAs, and slightly less than one-half (24) offered an orientation program for the assistants. Twelve participants omitted this question.

The orientation of GAs to their functions and responsibilities varied among the schools. Of the 24 schools that offered an orientation program for GAs, 11 indicated that the program was individualized; 9 explained that the orientation was mainly to specific responsibilities and functions; and 4 stated that it was the same program that was given for new faculty.

Faculty Beliefs Regarding the Use of GAs. Addressing faculty satisfaction with GAs, 26 of the schools (55 percent) gave positive expressions about the use and service of their GAs. Twenty-three percent (11) preferred to note that the assistantship provided the student with a learning opportunity. Six programs (13 percent) expressed mixed feelings about engaging graduate students in the nursing education program, noting a "wait-and-see" approach and stating that students needed to devote their time to course work. A few participants (9 percent) preferred not to respond to this question.

Implications and Recommendations

This survey of graduate assistantships in nursing education, largely a general overview, raises many provocative questions and presents several serious implications for graduate students and nursing education.

True, the graduate assistantship offers nursing students an avenue for financing their advanced nursing education as well as a means for acquiring some experience in teaching and/or research. But does the assistantship provide graduate students with a valuable learning experience in all cases? Approximately two-thirds of the schools reporting the use of GAs allow their graduate students to apply for an assistantship at any level in the graduate program, and only a few require a course in curriculum and instruction prior to their experience. Are students who are awarded an assistantship in the first semester of the graduate program and who do not have any knowledge or understanding of the principles and methods of curriculum and instruction prepared to assist with the teaching of undergraduate students? Should the undergraduate student be taught by a less-credentialed, less-experienced teacher than the qualified faculty? Ideally, should not the graduate student devote full time and attention, especially during the first year, to becoming adjusted to advanced academic study [*2*]?

Higher education has established the role of the graduate assistant over a period of several decades. It has been suggested that assistantships should be incorporated into master's degree and doctoral programs in nursing education [*14*]. Less than wide and rapid dissemination of this idea in graduate nursing education is probably advantageous at this time.

Establishing a sound GA system will require considerable time and energy on the part of the faculty. To be educationally sound, a GA system must include such components as well-defined selection criteria, an orientation program, an ongoing professional development program, and a system for supervision and evaluation of the GAs.

Nursing has yet to develop the graduate assistantship into a viable component of its graduate education—an avenue where students may gain experience in teaching and/or research. Studies of the various components of the GA system in nursing education are needed at this time. Graduate assistantships may not be a feasible and/or appropriate option for every graduate nursing education program. The inclusion of graduate assistantships in a school must be approached carefully and deliberately, with the understanding that the associated responsibilities will place demands on the faculty and, ultimately, on the budget.

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